DEPARTMENTS OF THE AIR FORCE,
THE ARMY, THE NAVY, AND TRANSPORTATION
Washington DC 20330-5000

AF REGULATION 160-13
AR 40-29
NAVMEDCOMINST 6120.2A
CGCOMDTINST M6120.8B
20 October 1989

Medical Service

MEDICAL EXAMINATION OF APPLICANTS FOR UNITED STATES SERVICE ACADEMIES, RESERVE OFFICER TRAINING CORPS (ROTC) SCHOLARSHIP PROGRAMS, INCLUDING 2- AND 3-YEAR COLLEGE SCHOLARSHIP PROGRAMS (CSP), AND THE UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES (USUHS)

This regulation gives a uniform procedure for carrying out medical examinations of applicants for US service academies, Reserve Officer Training Corps (ROTC) Scholarship Programs and the Uniformed Services University of the Health Sciences (USUHS). It applies to all medical facility personnel who perform such medical examinations, including the Air National Guard and US Air Force Reserve Units.

This regulation is affected by the Privacy Act of 1974. Each form required by this regulation and which involves the Privacy Act either contains a Privacy Act Statement incorporated in the body of the document or is covered by DD Form 2005, Privacy Act Statement—Health Care Records. For a list of abbreviations shown in this publication, see attachment 1.

Supersedes AFR 160-13, AR 40-29, NAVMEDCOMINST 6120.2, and CGCOMDTINST M6120.8A, 30 June 1986. (See signature page for summary of changes.)
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OPR: DODMERB/SAS (CMSgt J. Powers)
Approved by: HQ USAF/SGP (CAPT R. D. Symonds, USN)
Writer-Editor: Novella S. Hill
Distribution: See page

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1. General Provisions:

a. DD Forms 2351, DOD Medical Examination Review Board (DODMERB) Report of Medical Examination, and 2492, DOD Medical Examination Review Board (DODMERB) Report of Medical History, will be used to record

medical examination results for the DODMERB only. They will not be used to record the results of medical examinations for any other Department of Defense (DoD) medical examination.

b. Every authorized applicant for a United States service academy (Military, Naval, Air Force, Coast Guard, Merchant Marine), ROTC Scholarship Program, or the USUHS, must take a complete medical examination as described in this regulation. Physicians or dentists must not terminate the examination if they note presumably disqualifying defects.

c. An examinee's medical status is determined by the DODMERB. Examining physicians must not recommend waivers. They must not discuss with examinees how their medical findings affect examinee medical qualifications.

d. When the examinee wishes to present certificates from private physicians, or other forms of medical documentation, these documents must be sent to the address shown in paragraph 5c, with the completed examination. If an examinee wishes to submit evidence to rebut a medical disqualification by the DODMERB, the examinee must be advised to submit the material directly to the address in paragraph 5c. Such material should not be submitted to the examining physician, since that physician has no power to take further action.

e. The medical or dental examiner may, in the course of the medical examination or subsequent to it, discuss the findings of the examination with the examinee, parents, or guardians. The discussion must be limited to the medical significance of those findings, and recommendations must be related only to the examinee's health and well-being. The examiner must not relate the significance of any findings to the examinee's medical qualifications or disqualification for a service academy or ROTC scholarship program.

f. The medical or dental examiner must tell the examinee to seek further medical or dental care for any findings that may affect the examinee's health and well-being. As an example, if the blood pressure is elevated, the examinee must be told to see his or her own physician for further evaluation.

2. Authorized Applicants. Medical examinations are conducted for only those applicants the DODMERB has officially scheduled (Medical Treatment Facility (MTF) will have been officially notified of applicants who have been scheduled at their facility). If unscheduled applicants call or appear in person and request a medical examination, the medical facility will refer them to the DODMERB. The DODMERB notifies applicants of the date and times their examinations have been scheduled.

3. Where Examinations Will Be Performed. Applicants may take qualifying examinations only at those facilities the DODMERB designates.

4. Scheduling Notification to Examining Facilities. The DODMERB sends each examining facility a list of applicants scheduled for examination, about 15 days before the examination date. On the examination day, each examining facility will mark a copy of the list to identify any applicants who did not report for examination, and return it to the DODMERB immediately.

5. Completion and Disposition of Forms:

a. The examining dentist completes DD Form 2480, DOD Medical Examination Review Board (DODMERB) Report of Dental Examination, according to paragraph 9a, and signs it. The examining physician completes DD Form 2351 (attachment 2), and DD Form 2492 (attachment 3) according to paragraph 9b. The examining physician must sign and date the original DD Forms 2351 and 2492. Also, the medical officer responsible for the examination's accuracy and completeness must sign item 59 on the original DD Form 2351.

b. Within 10 workdays after the examination, the examining facility must send the following to the address in c below:

(1) The original DD Form 2351, properly signed and authenticated (see a above).

(2) Any consultation reports.

(3) Laboratory reports (if any, other than those recorded on DD Form 2351, items 27, 28, and 29).

(4) The DD Form 2492, signed by the examinee and the examining physician.

(5) The SF 520, Clinical Record—Electrocardiographic Record, showing electrocardiographic (ECG) tracings, properly mounted, identified, and interpreted. (Multiple channel ECGs need not be mounted).

(6) DD Form 2480, properly annotated and signed by the examining dentist (attachment 4).

(7) All dental radiographs (bite-wings and panoramic x-rays) properly processed.

(8) All medical documentation the examinee presented.

(9) Diagnostic dental casts, if required by paragraph 9a(4), sent in a separate package, marked with the examinee's name and social security number (SSN).

c. All items required by b above must be sent to the DODMERB. Assemble and staple all forms and dental radiographs in the order listed. Address material to: DOD Medical Examination Review Board (DODMERB), USAF Academy CO 80840-6518. DO NOT address mail to Commanding Officer, USAF Academy CO 80840-6518. This results in medical correspondence being routed to the Superintendent's office at the Air Force Academy, where it will be delayed in reaching the DODMERB.

d. The examining facility must keep one complete copy (carbon or duplicate) of each item in b above, except b(8), then dispose of these items according to parent service record disposition standards; e.g., AFR 12-50, volume II.

e. Some helpful hints:

(1) Do:

(a) Mail as many examination reports in one package as possible.

(b) Send packages weighing 12 ounces or less as First-Class Mail.

(c) Send packages weighing over 12 ounces as "Priority" mail.

(d) Staple all papers and x-rays in the **upper left corner.**

(e) Review all items for legibility and positive identification of the examinee.

(2) **Do Not:**

(a) Send a letter of transmittal.

(b) Complete or send any Privacy Act Statement (DD Form 2005, Privacy Act Statement—Health Care Records).

(c) Send medical examination reports or remedial medical information via Certified or Registered mail.

6. Hospitalization of an Applicant. When hospitalization is required as part of the medical examination, the applicant may be admitted to a DOD MTF under the authority of appropriate service regulations; e.g., AFR 168-6, AR 40-3, NAVMEDCOMINST 6320.3, Uniform Military Training and Service Act (62 Stat 604.50 U.S.C., App 451).

7. Civilian Consultation and Additional Evaluations. When supplemental reports, such as specialty consultations and laboratory procedures, are essential to evaluate an examinee properly, the examining facility should do them whenever possible.

a. If these services are not available, the facility may purchase these services from civilian sources, at government expense, providing funds are available. If funds are not available, or these service cannot be offered because of scheduling, distance, or the like, *the examinee must be given the opportunity to travel at his or her own expense to a government facility that can provide these services.* In that case, tell the examinee to call the other government facility for an appointment in advance. The examinee may also get these services, at his or her own expense, from a civilian source, and have results sent directly to the address in paragraph 5c. Applicant should be provided SF 513, Medical Record—Consultation Sheet, which provides pertinent history and specifically delineates the specialty information needed and authorized lab tests required. Invasive or potentially dangerous procedures are not authorized. Communicate with DODMERB in questionable cases.

b. Results of the medical examination should be sent without waiting for supplementary evaluations or their results. Any instructions given to the examinee will be explained on DD Form 2351. Results of additional tests or evaluations should be sent separately, when they become available.

8. Direct Communication. The Director, DODMERB, is authorized to communicate directly with the commanders of each designated examining facility about medical examinations, procedures, techniques, deficiencies, and general supervision of medical examination processing. The Director, DODMERB, may send a copy of any correspondence with the examining facilities to the office of primary responsibility of the appropriate Surgeon General office.

9. Scope of Examination:

a. Dental Examination:

(1) General Information. The dental officer thoroughly examines the mouth, teeth, and supporting structures of the examinee and records his or her findings in blue-black or black ink on the DD Form 2480 (attachment 4). While the examining dental officer must inform the candidate of existing deficiencies, pathology, or abnormalities, the examiner is not authorized to advise the examiner whether or not he or she is within dental standards. Therefore, the dental

examiner should not point out the specific treatment that might be needed to meet the standards. If such instructions are necessary, the DODMERB must give these instructions to the examinee after evaluating all results of the dental examination. Generally, all dental expenses will be borne by the examinee. Dental radiographs and study casts are authorized to be obtained from the Departments of the Army, Navy and Air Force dental facilities at no expense to the examinee.

(2) Dental Radiographs. All examinees receive the Type 2 Dental Examination. This includes both mirror and explorer examination under adequate illumination. Bite-wing radiographs on bite-wing film and a panoramic radiograph are required. When an examinee is wearing a fixed, active orthodontic appliance, excluding retainers on both arches, only a panoramic radiograph is required. Bite-wing x-rays are not needed in these cases. A full mouth x-ray survey should not be performed in place of a panoramic x-ray.

(a) If the examination facility does not have a panoramic x-ray, offer the examinee the opportunity to go to another government facility, traveling at his or her own expense. In such cases, advise the examinee to call for an appointment. As an alternative, the examinee may obtain the panoramic x-ray (and not a full-mouth survey) from a civilian dentist at his or her own expense.

(b) The examining dental officer may obtain additional radiographs (for example, periapical or occlusal views) if it is necessary to demonstrate pathology or other abnormalities.

(c) Identify all radiographs with the examinee's full name and SSN. Process thoroughly, and wash and dry radiographs before sending them to the DODMERB. All x-rays must be of diagnostic quality.

(3) Charting Dental Defects. All dental defects of the examinee are shown on DD Form 2480. Indicate on the chart (DD Form 2480, item 3) all teeth that are restorable or nonrestorable, missing teeth, teeth replaced, spaces closed, location of cavities, and any defects or abnormalities of the teeth and surrounding structures. Do not chart existing restorations unless they are defective.

(4) Diagnostic Dental Casts. In cases of questionable occlusion, disfiguring spaces between anterior teeth, malformation of the jaw, or malrelation of the jaw, dental casts must be made of maxillary and mandibular dental arches. Leave any existing prosthetic appliances in place when you make impressions. Draw pencil lines across facial surfaces of both casts to show the habitual occlusal relationship. Identify each cast clearly with the examinee's name and SSN, and send both casts to the DODMERB. Indicate on DD Form 2480, item 10l, that you are sending casts.

(5) Malocclusion. Any questionable occlusion or definite malocclusion related to an insufficient incisal or masticatory function, the malformation or malrelation of jaws or opposing teeth, or a facial deformity must be noted on the DD Form 2480, item 10. Any additional remarks about the type, degree, or severity of the malocclusion should be added in item 16 (attachment 4).

(6) Orthodontics. If the examinee wears a fixed, active orthodontic appliance, or is undergoing orthodontic treatment that includes an active removable appliance, or is wearing retainer appliances, or has a past history of orthodontic treatment, please note that fact on the DD Form 2480, item 11.

(7) Periodontal Conditions. If significant periodontal disease is present (not simply gingivitis), the location, nature, and severity of the problem must be described on the DD Form 2480, item 13.

(8) Dental Prostheses. The dental examination must include an opinion about the serviceability of all dental prostheses. A serviceable prosthesis must adequately restore masticatory function and appearance, and permit clear speech. Oral tissues supporting the prosthesis must be healthy. Any comments must be recorded on the DD Form 2480, item 12.

(9) Cleft Palate or Cleft Lip. If the examinee has a history of cleft palate or cleft lip, whether repaired or not, your comments must be recorded on the DD Form 2480, item 9d and e, to include existing fistulae or other defects.

b. Medical Examinations:

(1) DD Form 2492, DODMERB Report of Medical History:

(a) The examinee's complete medical history must be recorded on the DD Form 2492.

(b) The examinee completes the first two lines, all of Sections I and II (items 1 through 94), and the Remarks (if necessary) of the DD Form 2492 in his or her own handwriting, using blue-black or black ink or indelible pencil.

(c) The examinee's identification is self-explanatory, but you may help the examinee fill out these items in the standard format.

(d) The examinee completes items 1 through 94 and Remarks (the examinee should mark "Not Applicable" or "N/A" in item 9, if appropriate). If item 21 "wear contact lenses or ocular eye retainers," is marked "yes," explain type of lenses or retainers and length of time removed before examination (see attachment 3). As the examinee may give vague or imprecise information in the "Remarks" section, all answers must be carefully reviewed, and the examinee asked to clarify answers, whenever necessary (note that answers in items 1 through 10 do not need remarks). The examiner must elaborate on medical history items that are not adequately explained by examinee.

(e) Some general guides for completing examiner's summary and elaboration of pertinent data:

1. Do not use the term "usual childhood illnesses." You may group childhood illnesses together, listing each one.

2. Record the date or age of incidents.

3. Do not use "NS" or "nonsymptomatic" in the history. You may use "NCNS," "no comp, no seq," or "no complications, no sequelae" after items of history.

4. Elaborate on all items of history answered "Yes" that are not adequately explained by examinee. Number your amplifying responses to correspond to the affirmative responses on DD Form 2492.

(2) DD Form 2351. Attachment 2 gives an item-by-item explanation of DD Form 2351, with model entries. Complete all items, as specified.

10. Supply of Forms:

a. DD Forms 2351, 2480, and 2492 are part of the scheduling package DODMERB sends to lists of applicants provided by the academies, ROTC programs and the USUHS.

b. Local reproduction of blank DD Forms 2351, 2480, and 2492 is authorized by the Army, Navy, Coast Guard, and Air Force through the applicable forms manager and reproduction facility. Print DD Forms 2480 and 2492 head-to-foot. Print DD Form 2351 face only.

c. The DD Forms listed below are provided to the applicant by DODMERB when remedial medical tests are required; however, a small stock of these forms will be maintained by each medical facility in the event applicants arrive at the medical facility without the appropriate forms to record remedial test results. Local reproduction is authorized based on the specific requirement of the particular agency.

(1) DD Form 2369, DOD Medical Examination Review Board (DODMERB) Cycloplegic Refraction (attachment 5).

(2) DD Form 2370, DOD Medical Examination Review Board (DODMERB) Three-Day Blood Pressure and Pulse Check (attachment 6).

(3) DD Form 2371, DOD Medical Examination Review Board (DODMERB) Update of Applicant's Medical Examination (attachment 7).

(4) DD Form 2372, DOD Medical Examination Review Board (DODMERB) Statement of Present Health (attachment 8).

(5) DD Form 2374, DOD Medical Examination Review Board (DODMERB) Heart Murmur Evaluation (attachment 9).

(6) DD Form 2375, DOD Medical Examination Review Board (DODMERB) Pulmonary Function Studies (attachment 10).

(7) DD Form 2377, DOD Medical Examination Review Board (DODMERB) Red/Green Color Vision Test (attachment 11).

(8) DD Form 2378, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Headaches (attachment 12).

(9) DD Form 2379, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Head Injury (attachment 13).

(10) DD Form 2380, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Sleepwalking (attachment 14).

(11) DD Form 2381, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Motion Sickness (attachment 15).

(12) DD Form 2382, DOD Medical Examination Review Board (DODMERB) Statement of History Regarding Hay Fever, Sinusitis, Asthma and/or Allergies (attachment 16).

(13) DD Form 2383, DOD Medical Examination Review Board (DODMERB) Statement of Use Regarding Medication (attachment 17).

(14) DD Form 2489, DOD Medical Examination Review Board (DODMERB) Farnsworth Lantern Color Vision Test (attachment 18). When locally reproduced, print head-to-foot.

d. DD Forms 2368, DOD Medical Examination Review Board (DODMERB) Service Academy ROTC Medical Qualification Determination; 2373, DOD Medical Examination Review Board (DODMERB) Notification of Failure to Appear for Service Academy ROTC Medical

Examination; and 2503, DOD Medical Examination Review Board (DODMERB) Applicant Overseas Appointment, are stocked and used only by DODMERB.

e. Attachment 19 provides guidelines for conducting certain medical tests; e.g., Reading Aloud Test (RAT), sitting height, Red Lens Test, etc.

BY ORDER OF THE SECRETARIES OF THE AIR FORCE, THE ARMY, THE NAVY, AND THE DEPARTMENT OF TRANSPORTATION

OFFICIAL

LARRY D. WELCH, General, USAF
Chief of Staff

WILLIAM O. NATIONS, Colonel, USAF
Director of Information Management
and Administration

OFFICIAL

CARL E. VUONO
General, United States Army
Chief of Staff

MILTON H. HAMILTON
Administrative Assistant to the
Secretary of the Army

OFFICIAL

H. JAMES T. SEARS
Rear Admiral, Medical Corps
United States Navy
Commander, Naval Medical
Command

OFFICIAL

MICHAEL HUDGINS
RADM, USPHS
Chief, Office of Health and Safety
US Coast Guard

SUMMARY OF CHANGES

This revision clarifies procedures MTFs will follow when applicants arrive who are not scheduled by DODMERB (para 2); permits the use of DD Form 2492 as an exception to SF 93, Report of Medical History, which will be used to report a medical history to DODMERB (paras 5a and 9b); advises examining facilities of the proper format for addressing medical correspondence to the DODMERB (para 5c); includes remedial medical information as being prohibited from being mailed Certified or Registered Mail (para 5e(2)(c); clarifies procedures examining physicians will follow when applicant must be hospitalized as part of the medical examination (para 6); adds additional information about applicants requiring specialty consultations and laboratory procedures before their examination (para 7); redesignates DODMERB Form 6, Report of Dental Examination to DD Form 2480 (para 9a); adds a list of abbreviations (atch 1); adds an explanation and model entry for blood alcohol testing and urine drug screen (atch 2, item 29); rescinds DD Form 2376, Supplemental Statement of Medical History.

Distribution:
Air Force: F
Army: Active Army, ARNG, USAR: To be distributed in accordance with the requirements on DA Form 12-09-E, block number 3434, intended for command level B.
Navy: Ships and Stations Having Medical Department Personnel.
(Stocked: CO, NAVPUBFORMCEN, 5801 Tabor Ave., Phila., PA 19120-5099)
Coast Guard: To be distributed by Commandant (G-TIS) pursuant to COMDTNOTE 5600

LIST OF ABBREVIATIONS

ANSI—American National Standards Institute
ASA—American Standards Association

BAT—Blood Alcohol Test

cm—Centimeters
CSP—College Scholarship Program
CT—Cover Test

°—Degree
DOD—Department of Defense
DODMERB—Department of Defense, Medical Examination Review Board
DPA-V—Depth Perception Apparatus—Verhoeff

ECG—Electrocardiographic
EKG—Electrocardiogram

FALANT—Farnsworth Lantern

GU—Genitourinary System

HIV—Human Immune Virus
Hz—Hertz

ISO—International Standards Organization

mm—Millimeters
MTF—Medical Treatment Facility

NCNS—No Complications, No Sequelae
NE—Not Examined
NPC—Near Point of Convergence
NS—Nonsymptomatic

OTC—Over the Counter

PA—Physician Assistant
PAS—Privacy Act Statement
PC—Point of Convergence
PCNP—Primary Care Nurse Practitioner
POC—Professional Officer Course

RAT—Reading Aloud Test
RBC—Red Blood Cell
ROTC—Reserve Officer Training Corps

SSN—Social Security Number

UDS—Urine Drug Screen
USUHS—Uniformed Services University of the Health Sciences

VTA-ND—Vision Test Apparatus—Near and Distant

VTS-CV—Vision Test Set—Color Vision

WBC—White Blood Cell
WHNS—Well Healed, No Sequelae

DD FORM 2351, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION
(This form is affected by the Privacy Act of 1974 - See DD Form 2005)

1. DATE OF EXAMINATION: 30 Sep 85

APPLICANT DATA

2. NAME (Last, First, Middle)	3. SOCIAL SECURITY NO.	4a. DATE OF BIRTH	b. AGE	5. SEX	6. RACE (Ethnic Group)
JONES, HARRY WILLIAM, JR.	111-22-3333	29 Jun 67	18	MALE	CAUCASIAN

7. HOME ADDRESS (Street, City, State and Zip Code)	8. MILITARY STATUS (X One)	9. EXAMINER ADDRESS (Street, City, State and Zip Code)
1234 Main Street Colorado Springs CO 80918-2228	a. ACTIVE DUTY X b. CIVILIAN c. RESERVE/GUARD	USAFA Clinic/SGP USAF Academy Colorado Springs CO 80840-5000

MEASUREMENTS

10. HEIGHT a. STANDING	10. HEIGHT b. SITTING	11. BLOOD PRESSURE	12. EKG	14. READING ALOUD TEST
72	37½	118/72	X a. NORMAL	X a. SATISFACTORY
16. WEIGHT 200		15. PULSE 7	b. ABNORMAL	b. UNSATISFACTORY (Explain in Item 57)

13. AUDIOMETER

	500	1000	2000	3000	4000	6000
RIGHT	5	5	5	10	5	10
LEFT	5	5	5	5	0	10

17. DISTANT VISION		18. REFRACTION			19. NEAR VISION	
a. RIGHT 20/ 25	b. CORR TO 20/ 20	(1) SPH -0.25	(2) CYL +0.25	(3) AXIS 100	a. 20/ 20	b. CORR TO 20/ c. BY
c. LEFT 20/ 25	d. CORR TO 20/ 20	(4) SPH -0.25	(5) CYL +0.25	(6) AXIS 090	d. 20/ 25	e. CORR TO 20/ 20 f. BY SAME

18. REFRACTION: a. CYCLO [ ] X [ ] b. MANIFEST [ ] c. LENS

20. HETEROPHORIA (Far only)				21. COVER TEST		22. COLOR VISION			23. DEPTH PERCEPTION	
a. ES°	b. EX°	c. R.H.	d. L.H.	X a. PASS		a. TEST USED	b. RESULTS		a. TEST USED	b. SCORE
5	0	1	0	b. FAIL		(1) VTS-CV	No. Passed	No. Failed	X (1) VTA-ND PASSES	(1) F
						X (2) FALANT 9/9			(2) DPA-V	(2)
						(3) OTHER (Specify)			(3) TITMUS/STEREO FLY	(3)

24. PC	25. ACCOMMODATION		26. RED LENS TEST		
70mm	a. RIGHT 8.0	b. LEFT 8.8	X a. PASS		b. FAIL

LABORATORY

27. URINALYSIS												28. BLOOD		29. OTHER TESTS (Specify type and results)
a. PROTEIN		NEG	X	T		1+		2+		3+		4+	a. TYPE O	c. HEMATOCRIT 48	
b. SUGAR	X	NEG		T		1+		2+		3+		4+	b. RH FACTOR +	d. HEMOGLOBIN 16.8	
c. MICROSCOPIC EXAMINATION (X One)			X	(1) NEGATIVE				(2) POSITIVE (List results)						

CLINICAL EVALUATION

NORMAL	X each item in the appropriate column (Enter "NE" if not evaluated)	ABNORMAL
X	30. HEAD, FACE, NECK AND SCALP	
X	31. NOSE	
X	32. SINUSES	
X	33. MOUTH AND THROAT	
	34. EARS - GENERAL (Internal and external canals) (Auditory acuity under item 13)	X
X	35. DRUMS (Perforation)	
X	36. VALSALVA	
X	37. EYES-GENERAL (Visual acuity and refraction under items 17, 18, and 19)	
X	38. PUPILS (Equality and reaction)	
X	39. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
X	40. OPHTHALMOSCOPIC	
X	41. LUNGS AND CHEST (Include breasts)	
X	42. HEART (Thrust, size, rhythm, and sounds)	
X	43. VASCULAR SYSTEM (Varicosities, etc.)	
X	44. ABDOMEN AND VISCERA (Include hernia)	
X	45. ENDOCRINE SYSTEM	
	46. SPINE, OTHER MUSCULOSKELETAL	X
X	47. UPPER EXTREMITIES (Strength, range of motion)	
X	48. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
X	49. FEET	
	50. IDENTIFYING BODY MARKS, SCARS, TATTOOS	X
X	51. SKIN, LYMPHATICS	
	52. G-U SYSTEM	X
X	53. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate if indicated)	
NE	54. PELVIC EXAMINATION	
X	55. NEUROLOGIC	
X	56. PSYCHIATRIC (Specify any personality deviation)	

57. NOTES (Describe every abnormality in detail. Enter the item number before each comment. Continue on reverse if necessary.)

34. 4cm post auricular surgical scar, left, WHNS.

46. Moderate dextroscoliosis, asymptomatic.
50. 1cm vertical scar, dorsum left forearm, WHNS.
52. Large left varicocele, asymptomatic.
56. Recommend for service academies and ROTC programs.

58. EXAMINER

a. TYPED OR PRINTED NAME	b. SIGNATURE
WILLIAM P. COX	William P. Cox
c. RANK: TSGT	d. CORPS OR DEGREE: 90270C

59. PHYSICIAN

a. TYPED OR PRINTED NAME	b. RANK	c. DEGREE	d. SIGNATURE
LARRY D. JONES	COL	MD	Larry D Jones

DD Form 2351, SEP 85 — DD Exception to SF 88 Approved by GSA/OIRM 7 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL EXAMINATION
(This form is affected by the Privacy Act of 1974 – See DD Form 2005)

1. DATE OF EXAMINATION

APPLICANT DATA

2. NAME (Last, First, Middle) | 3. SOCIAL SECURITY NO. | 4a. DATE OF BIRTH | b. AGE | 5. SEX | 6. RACE (Ethnic Group)

7. HOME ADDRESS (Street, City, State and Zip Code)

8. MILITARY STATUS (X One)
- a. ACTIVE DUTY
- b. CIVILIAN
- c. RESERVE/GUARD

9. EXAMINER ADDRESS (Street, City, State and Zip Code)

MEASUREMENTS

10. HEIGHT: a. STANDING | b. SITTING

11. BLOOD PRESSURE

12. EKG: a. NORMAL | b. ABNORMAL

13. AUDIOMETER

	500	1000	2000	3000	4000	6000
RIGHT						
LEFT						

14. READING ALOUD TEST: a. SATISFACTORY | b. UNSATISFACTORY (Explain in Item 57)

15. PULSE

16. WEIGHT

17. DISTANT VISION: a. RIGHT 20/ | b. CORR TO 20/ | c. LEFT 20/ | d. CORR TO 20/

18. REFRACTION: a. CYCLO | b. MANIFEST | c. LENS
(1) SPH | (2) CYL | (3) AXIS | (4) SPH | (5) CYL | (6) AXIS

19. NEAR VISION: a. 20/ | b. CORR TO 20/ | c. BY | d. 20/ | e. CORR TO 20/ | f. BY

20. HETEROPHORIA (Far only): a. ES° | b. EX° | c. R.H. | d. L.H.

21. COVER TEST: a. PASS | b. FAIL

22. COLOR VISION
a. TEST USED | b. RESULTS
(1) VTS-CV — No. Passed — No. Failed
(2) FALANT
(3) OTHER (Specify)

23. DEPTH PERCEPTION
a. TEST USED | b. SCORE
(1) VTA-ND (1)
(2) OPA-V (2)
(3) TITMUS/STEREO FLY (3)

24. PC

25. ACCOMMODATION: a. RIGHT | b. LEFT

26. RED LENS TEST: a. PASS | b. FAIL

LABORATORY

27. URINALYSIS
a. PROTEIN — NEG · T · 1+ · 2+ · 3+ · 4+
b. SUGAR — NEG · T · 1+ · 2+ · 3+ · 4+
c. MICROSCOPIC EXAMINATION (X One) — (1) NEGATIVE | (2) POSITIVE (List results)

28. BLOOD: a. TYPE | c. HEMATOCRIT | b. RH FACTOR | d. HEMOGLOBIN

29. OTHER TESTS (Specify type and results)

CLINICAL EVALUATION

NORMAL	X each item in the appropriate column (Enter "NE" if not evaluated)	ABNORMAL
	30. HEAD, FACE, NECK AND SCALP	
	31. NOSE	
	32. SINUSES	
	33. MOUTH AND THROAT	
	34. EARS - GENERAL (Internal and external canals) (Auditory acuity under item 13)	
	35. DRUMS (Perforation)	
	36. VALSALVA	
	37. EYES-GENERAL (Visual acuity and refraction under items 17, 18, and 19)	
	38. PUPILS (Equality and reaction)	
	39. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	40. OPHTHALMOSCOPIC	
	41. LUNGS AND CHEST (Include breasts)	
	42. HEART (Thrust, size, rhythm, and sounds)	
	43. VASCULAR SYSTEM (Varicosities, etc.)	
	44. ABDOMEN AND VISCERA (Include hernia)	
	45. ENDOCRINE SYSTEM	
	46. SPINE, OTHER MUSCULOSKELETAL	
	47. UPPER EXTREMITIES (Strength, range of motion)	
	48. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	49. FEET	
	50. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	51. SKIN, LYMPHATICS	
	52. G-U SYSTEM	
	53. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate if indicated)	
	54. PELVIC EXAMINATION	
	55. NEUROLOGIC	
	56. PSYCHIATRIC (Specify any personality deviation)	

57. NOTES (Describe every abnormality in detail. Enter the item number before each comment. Continue on reverse if necessary.)

58. EXAMINER
a. TYPED OR PRINTED NAME | b. SIGNATURE
c. RANK | d. CORPS OR DEGREE

59. PHYSICIAN
a. TYPED OR PRINTED NAME | b. RANK | c. DEGREE | d. SIGNATURE

DD Form 2351, SEP 85

DoD Exception to SF 88 Approved by GSA/OIRM 7-85

ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2351

Explanation	Model Entry
Item 1—Date of Examination. Record dates in military style.	14 January 1985 21 Mar 85
Item 2—Last Name, First Name, Middle Name. Record the entire middle name.	Jones, Harry William, Jr. Martinez, Catherine, Lucinda
Item 3—Social Security Number.	111-22-3333 001-01-1001
Item 4a—Date of Birth. Record date in military style.	15 Feb 68 29 Apr 67
Item 4b—Age.	17 18
Item 5—Sex. Do not abbreviate.	Male Female
Item 6—Race (Ethnic Group). Do not abbreviate. Do not confuse with religion.	Caucasian, Black, Oriental, Indian (American), Puerto Rican, Mexican-American
Item 7—Home Address. Enter the address and nine-digit ZIP code where the examinee receives mail.	1234 Main St. Colorado Springs CO 80840-6518
Item 8—Military Status. Check the block designating the applicant's current status.	
Item 9—Examiner Address. Complete name and address of agency doing examination	USAF School of Aerospace Medicine Brooks AFB TX 78235-5000
Item 10—Height. Record standing height in inches, without shoes, to the nearest quarter of an inch. Also measure every applicant's sitting height to the nearest quarter of an inch, and record it.	Standing 61 1/4 Sitting 36 3/4
Item 11—Blood Pressure. Record the sitting blood pressure.	120/84
Item 12—Electrocardiogram (EKG). Give every examinee a 12-lead EKG. The examinee does not have to be fasting. Check normal or abnormal, and submit actual tracings.	
Item 13—Audiometer. Give an audiometer test, include frequencies 500, 1000, 2000, 3000, 4000, and 6000 Hertz (Hz). Indicate the type of standard (American National Standards Institute (ANSI) American Standards Association (ASA), 1951, or International Standards Organization (ISO), 1964.	
Item 14—Reading Aloud Test (RAT). Give the RAT (attachment 19) and mark it as "satisfactory" or "unsatisfactory." If RAT is unsatisfactory, summarize the defects that caused failure in item 57.	
Item 15—Pulse. Record the resting pulse in beats per minute.	72
Item 16—Weight. Measure weight in pounds, to the nearest whole pound, with the examinee wearing no more than underwear.	150

Explanation	Model Entry
Items 17 through 26. Before conducting vision test, find out if the examinee is wearing contact lenses. Soft contact lenses must be removed a minimum of 3 days before the examination. All other types of contact lenses (hard, semisoft, retainers, color-correcting, etc.) must be removed 21 days before the examination. If contact lenses have not been out the required period of time, note the fact in item 57 and continue with the examination. Have the examinee remove them for those tests where lenses would obviously cause erroneous results, such as items 17 and 19 (uncorrected vision). If the examinee usually wears corrective lenses (spectacles or contacts), have the examinee wear them during depth perception and color vision testing; however, make sure that lenses are not "color corrective."	
Item 17—Distant Vision. Record distant visual acuity with a constant numerator of 20 (20 feet), and a denominator that depends on the individual's vision. If acuity is worse than 20/20, right eye or left eye, then record the correctable visual acuity. If the examinee is not able to read *all* of the letters on the 20/20 line, then record the number of missed letters; e.g., 20/20–1; 20/30–2; 20/20–3, etc., or record the next higher line; e.g., 20/20–3 = 20/25. Measure visual acuity with Vision Test Apparatus-Near and Distant (VTA-ND), or in the eye lane. When using the VTA-ND and the examinee does not successfully complete the top line of the 20/400 line, then record 20/400+ or refer examinee to the optometrist to determine the proper visual acuity.	20/50 corrected to 20/20 20/20–3 corrected to 20/20 20/400+
Item 18—Refraction. OTHER THAN US AIR FORCE ACADEMY. Complete this item on every examination where distant or near visual acuity is worse than 20/20, right eye or left eye. Enter the prescription that corrects acuity to 20/20, and after the word "Refraction" mark how you derived that prescription; "manifest," "cycloplegic," or "lens" if the prescription is read from spectacles.	Refraction (manifest By SPH *–1.50* CYL *+.50* AXIS *090*
US AIR FORCE ACADEMY. Every applicant for the US Air Force Academy whose uncorrected distant visual acuity is 20/20 or better in both the right and left eyes must have a cycloplegic refraction. Enter the prescription that corrects acuity to no better than 20/20 and after the word "Refraction" check "CYCLO."	
Item 19—Near Vision. Record results in terms of reduced Snellen. Whenever the uncorrected vision is worse than normal (20/20), show the corrected vision for each eye, and lens value after the word "by."	20/40 corrected to 20/20 by same. 20/40 corrected to 20/20 by +0.50
Item 20—Heterophoria. In routine testing for heterophoria, check only "Far" on the VTA-ND, or "20" in the eye lane. Do not enter the symbol for diopters; the unit of measurement is understood. Enter the amount of exophoria or esophoria and right or left hyperphoria.	Es° Ex° R.H. L.H. 8 0 1 0

Explanation	Model Entry
Item 21—Cover Test. Test muscle balance deviation (phorias or tropias) by use of the objective Cover Test (CT). If you find esotropia or exotropia on the CT (cross or alternate cover and cover-uncover) check "fail" and record the amount in the bottom of the box. If the examinee is orthophoric, check "pass."	
Item 22—Color Vision. Test examinees with the standard 15-plate Vision Test Set, Color Vision (VTS-CV). Check the test(s) used and enter both the number passed and the number failed. If the Farnsworth Lantern (FALANT) is available, use it for those who fail the plate test. Also, use it if you suspect the examinee has memorized the plates. Enter FALANT results to the right of the word "FALANT." Be sure to specify the name of other tests and the numerical result. If the examinee fails the FALANT or 15-plate Vision Test Set, check for the ability to distinguish and identify, without confusion, those colors of objects, substances, materials, or lights that are vivid red and vivid green; record results in item 57.	
Item 23—Depth Perception. Test the examinee with correction, if any. For VTA-ND if the examinee passes, enter "passes" and give the highest level passed (D, E, or F) in parentheses. For Verhoeff (DPA-V), enter "passes" or "fails" and the number correct over number presented. For Titmus/Stereo Fly, circle the actual test used and enter the numerical result.	a. VTA-ND *passes (F)* b. DPA-V *passes (8/8)* c. Titmus/Stereo Fly *70*
Item 24—PC (Near Point of Convergence). Measure the near point of convergence (NPC) in millimeters (mm).	35mm
Item 25—Accommodation. Have the examinee take this test with corrective lenses if worn.	Right 10.0, Left 9.5
Item 26—Red Lens Test. Note the point on the screen where diplopia or suppression develops. Mark "pass" if the examinee has no diplopia or suppression within 20 inches of the primary position in the center of screen, with the examinee seated 30 inches from the screen. Describe any abnormalities accurately in item 57.	Diplopia in left lateral gaze, 10 inches from primary position.
Item 27—Urinalysis. Check the appropriate boxes for protein and sugar. Indicate results of microscopic examination; multi-reagent strips may be used if negative. If the multireagent strip is not negative, an actual microscopic examination must be performed and the results annotated.	2 RBC 3 WBC
Item 28a and b—Blood Type and RH Factor. Record results in these blocks.	Type A Rh factor—Pos
Item 28c and d—Hematocrit and Hemoglobin. A hematocrit or hemoglobin level is required.	Hematocrit 44 Hemoglobin 16.5
Item 29—Other Tests. For other medical tests as indicated; e.g., HIV (all exams), dental results (POC only), blood alcohol testing (BAT) and urine drug screen (UDS).	HIV—Negative Dental Class 2 BAT—Negative UDS—Collected

Explanation	Model Entry
Items 30 through 56—Clinical Evaluation. Make a check in the proper column. When there are clinical findings to record or comment on, check the proper column (normal or abnormal) and enter pertinent information in the space provided to the right, beginning with the item number. (See instructions on DD Form 2351).	
Item 30—Head, Neck, Face, and Scalp. Record all swollen glands, deformities, or imperfections of the head and face. If enlarged lymph nodes of the neck are detected, describe them in detail and give a clinical opinion of the etiology.	a. 2cm vertical scar right forehead, well healed, no sequelae (WHNS). b. 2 discrete, freely movable, firm, 2cm nodes in right anterior cervical chain, probably benign. Has upper respiratory infection.
Item 31—Nose. Record all abnormal findings. If septum is deviated, estimate the degree of obstruction and tell whether airflow is adequate.	a. Moderate obstruction on right, due to septal deviation, airflow adequate, asymptomatic. b. Mouth breathing noted. c. Large nasal polyps present in both chambers.
Item 32—Sinuses. Record objective findings only.	Marked tenderness over left maxillary sinus. Poor transillumination.
Item 33—Mouth and Throat. Note whether tonsils have been removed. Record any unusual findings.	Tonsils enucleated.
Item 34—Ears—General (Including External Canals). If operative scars are noted over the mastoid area, include a notation of simple or radical mastoidectomy in item 57.	Bilateral severe swelling, injection, and tenderness of ear canals.
Item 35—Drums (Perforation). Record the location and size of any perforation. If there is scarring of the tympanic membrane, record the percent of the membrane involved, and evaluate the mobility of the membrane.	Small perforation, right upper quadrant of left tympanum.
Item 36—Valsalva. Indicate whether or not *both* eardrums move on Valsalva Maneuver (mark normal only if both drums move).	No motion on valsalva, right ear.
Item 37—Eyes—General. When there is ptosis of lids, make a statement about the cause and whether it interferes with vision. When you detect a pterygium, note the following: (a) Encroachment on the cornea. (b) Progression. (c) Vascularity. Check particularly for radial keratotomy or evidence of orthokeratology or other procedures employed to improve visual acuity.	a. Ptosis, bilateral, congenital. Does not interfere with vision. b. Pterygium, left eye. Does not encroach on cornea, nonprogressive avascular.
Item 38—Pupils (Equality and Reaction).	
Item 39—Ocular Motility (Associated Parallel Movements, Nystagmus).	
Item 40—Ophthalmoscopic. If you detect opacities of the lens, make a statement about size, type, progression, and interference with vision.	Redistribution of pigment, macula, right eye, possibly due to solar burn. No evidence of active organic disease.

Explanation	Model Entry
Item 41—Lungs and Chest (Include Breasts). Record all abnormal findings. Note whether there are any abnormalities of the rib cage, muscles, chest excursion, palpation, percussion, and auscultation.	Sibilant and sonorus rales throughout chest. Prolonged expiration.
Item 42—Heart (Thrust, Size, Rhythm, Sounds). Describe any abnormal heart findings completely. Whenever you hear a cardiac murmur, describe the time in the cardiac cycle, and the intensity, location, transmission, and effect of respiration or change in position; and state whether you think that the murmur is organic or functional. When describing murmurs by grade, indicate basis of grade (IV or VI). Note any additional sounds (clicks, etc.) and their time in the cardiac cycle, synchrony, and intensity; and whether you think they are of cardiac origin or adventitious.	a. Grade II/IV soft, systolic murmur heard only in pulmonic area and on recumbency, not transmitted. disappears on exercise and deep inspiration (physiologic murmur) b. Late soft systolic "click" heard over the second left intercostal space, parasternally, not varying in intensity with respiration, probably of cardiac origin.
Item 43—Vascular System (Varicosities, etc.). Describe any abnormalities adequately. When varicose veins are present, give their location, severity, and evidence of venous insufficiency. Check for the presence or absence of carotid, radial, femoral, popliteal, and pedal pulses. Specifically, record any absent pulses or presence of a bruit over any artery.	Varicose veins, mild posterior superficial veins of legs. No evidence of venous insufficiency. Asymptomatic.
Item 44—Abdomen and Viscera (Include Hernia). Note any abdominal scars and describe the length in centimeters, their location and direction. If you find a dilated inguinal ring, state whether a hernia is present or absent.	2.5cm linear diagonal scar right lower quadrant, well healed, no sequelae (WHNS).
Item 45—Endocrine System. Specifically record asymmetry, enlargement, or the presence of nodules in the thyroid gland.	Left lobe diffusely enlarged; 2cm hard, nontender nodule near isthmus.
Item 46—Spine, Other Musculoskeletal (Including Pelvis, Sacroiliac, and Lumbosacral Joints). If you detect scoliosis or other musculoskeletal defects, either by examination or as an incidental chest x-ray finding, describe any defects as accurately as possible.	Scoliosis, thoracic spine, minimal deviation to right.
Item 47—Upper Extremities. Record any deformity or limitation of motion. If the applicant has a history of previous injuries or fracture of an upper extremity (for example, a history of a broken arm with no significant finding at time of examination), indicate that there is no deformity and function is normal. Make a positive statement, even though you check the "Normal" column.	No weakness, deformity or limitation of motion, left arm.
Item 48—Lower Extremities. Report as in item 47.	
Item 49—Feet. Note any abnormality. When you detect flat feet, make a statement about the stability and the presence or absence of symptoms. Do not express pes planus in degrees; record it as mild, moderate, or severe. Indicate if orthotic devices or special footwear are used.	Flat feet, moderate, stable, asymptomatic.
Item 50—Identifying Body Marks, Scars, or Tattoos. Record only scars or marks useful for identification.	a. 1cm vertical linear scar, dorsum left forearm, WHNS. b. 3cm heart-shaped tattoo, lateral aspect, middle 1/3 left forearm.

Explanation	Model Entry
Item 51—Skin, Lymphatics. Describe pilonidal cyst or sinus, and tell whether symptomatic in past or at present. If there is a skin disease, tell what it is, record its chronicity, severity, and response to treatment in item 57. If you detect a skin disease of the face, back, or shoulders, state whether the defect will interfere with wearing an oxygen mask or whether wearing a parachute harness, shoulder straps, or other military equipment will irritate it.	a. Acne vulgaris, mild, face, will not interfere with wearing oxygen mask or combat equipment. b. 5 × 5cm burn scar, left pretibial region. May be subject to trauma by combat boots, or breakdown by water immersion.
Item 52—GU (Genitourinary) System. If you detect a varicocele or hydrocele, indicate the size in relation to the opposite testicle and whether it is symptomatic. If you detect an undescended testicle, describe its location, particularly in relation to the inguinal canal.	Varicocele, left, small, asymptomatic
Item 53—Anus and Rectum. Check for hemorrhoids, and note size, number, and symptomatology. Check for fistula, cysts, etc. At least a visual examination is required on all examinees.	One small external hemorrhoid, asymptomatic.
Item 54—Pelvic Examination. Perform a pelvic examination only if medically indicated. If the examination is not performed, enter "NE" in the Normal column. This examination is required for all female examinees 22 years of age and over.	
Item 55—Neurologic. Record complete description of any abnormality.	
Item 56—Psychiatric. Interview each applicant to evaluate level of maturity, and ability to withstand the rigorous physical and mental stresses of military service. Explain any negative recommendations in detail.	
Item 57—Notes. Use this space to describe conditions found during the Clinical Evaluation (items 30 through 56). This space should be used for any other comments relating to items 10 through 29. Be sure to enter the item number before each comment. Use the back of the form, if necessary.	
Item 58a—Typed or Printed Name of Examiner. The examiner identified must sign the original. Use block for Physician Assistant (PA) or Primary Care Nurse Practitioners (PCNP) who perform clinical aspect of examination.	
Item 58b—Signature of Examiner.	
Item 58c—Rank.	
Item 58d—Corps or Degree.	
Item 59a—Typed or Printed Name of Physician.	
Item 59b—Rank.	
Item 59c—Degree.	

DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY—MALE

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY
(This information is for official and medically confidential use only and will not be released to unauthorized persons.)
(This form is subject to the Privacy Act of 1974 - See DD Form 2005)

Form Approved OMB No. 0704-0269 Expires Sep 30, 1989

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	TELEPHONE NO. (Include area code)
MORAY, HARRY G.	011-11-0001	(102) 962-0001

PURPOSE OF EXAMINATION	EXAMINATION FACILITY OR EXAMINER AND ADDRESS (Include Zip Code)	DATE OF EXAMINATION
DODMERB	USAF Clinic Hanscom, Hanscom Fld MA 01101	5 May 87

SECTION I – Mark applicable boxes in items 1 through 10

1. How would you rate your present health?
[X] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor

2. How many hours sleep do you usually get at night?
[ ] 4 or less [ ] 5 [ ] 6 [ ] 7 [X] 8 [ ] 9 or more

3. How many days per week do you exercise vigorously *(enough to produce a sweat)* **for at least fifteen minutes**
[ ] None [ ] 1 [ ] 2 [ ] 3 [X] 4 [ ] 5 [ ] 6 [ ] 7

4. Are you on any special diet?
[ ] Yes [X] No

5. Indicate the tobacco products you currently use.
[X] Cigarettes [ ] Cigars [ ] Chewing tobacco
[ ] Snuff (Smokeless tobacco) [ ] Pipes [ ] None *(Skip to item 7)*

6. If you smoke cigarettes how many do you smoke each day?
[X] Less than 1 pack [ ] 1 pack [ ] 1 1/2 packs [ ] 2 packs or more

7. On the average, how many times per week do you drink any alcoholic beverages such as beer, wine, or liquor?
[X] Never *(skip to item 9)* [ ] Less than once [ ] Once or twice [ ] Three or four [ ] Five or more

8. When you drink, how many alcoholic drinks do you have *(on the average)*?
[ ] 1 [X] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 or more

9. Have you ever used any of the following? N/A
[ ] Amphetamines [ ] Barbiturates [ ] Chemical inhalants
[ ] Cocaine [ ] Hallucinogens [ ] Narcotic drugs

10. What is your marital status?
[X] Never Married [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

SECTION II – Mark each item *(11 through 94)* "Yes" or "No." If you do not know the answer for a particular item, leave it blank. Every item marked "Yes" must be explained in the REMARKS section on the reverse.

A. Does your family have a history of	Yes	No
11 Diabetes or sugar diabetes		X
12 Heart trouble or strokes		X
13 High blood pressure		X
14 Cancer		X
15 Mental condition		X
16 Alcoholism or suicide		X
17 Seizures or epilepsy		X
18 Allergies or Asthma		X
19 Arthritis or rheumatism		X
B. Do you or did you ever		
20 Wear glasses		X
21 Wear contact lenses or ocular eye retainers	X	
22 Have any allergies	X	
23 Take any medications regularly		X
24 Stutter or stammer		X
25 Wear a bone or joint brace or support		X
C. Have you ever had or do you now have		
26 Frequent, severe, or migraine headaches		X
27 Fainting or dizzy spells		X
28 Periods of unconsciousness	X	
29 Head injury or skull fracture	X	
30 Epilepsy, seizures, or convulsions		X
31 Loss of memory or amnesia		X
32 Depression, excessive worry or nervousness, anxiety		X
33 Any mental condition or illness		X
34 Frequent trouble sleeping		X

C. (Contd.) Have you ever had or do you now have	Yes	No
35 Eye trouble *(exclude glasses, contact lenses)*		X
36 Vision change or double vision		X
37 Hearing loss		X
38 Ear, nose, or throat trouble		X
39 Sinusitis or sinus trouble		X
40 Hay fever or allergic rhinitis		X
41 Severe tooth or gum trouble	X	
42 Thyroid trouble		X
43 Chronic cough or lung disease		X
44 Asthma or wheezing		X
45 Unusual shortness of breath		X
46 Pain or pressure in chest		X
47 Palpitation or pounding heart		X
48 Heart trouble or heart murmur		X
49 High blood pressure		X
50 Coughed up or vomited blood		X
51 Stomach, liver, or intestinal trouble		X
52 Gallbladder trouble or gallstones		X
53 Yellow jaundice or hepatitis		X
54 Hemorrhoids or rectal disease		X
55 Black or bloody stools		X
56 Frequent or painful urination		X
57 Bed wetting since age 12		X
58 Blood, protein, or sugar in urine		X
59 Kidney stone		X
60 Hernia or rupture		X
61 Any bone or joint trouble, bursitis		X
62 Broken bones or amputations		X
63 Steel pins, plates, or staples in any bones		X

C. (Contd.) Have you ever had or do you now have	Yes	No
64 Back pain or trouble		X
65 Paralysis, lameness, or weakness		X
66 Foot trouble	X	
67 Rheumatic fever		X
68 Tuberculosis or positive TB test		X
69 Homosexual activity		X
70 VD, syphilis, gonorrhea, herpes, etc.		X
71 Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin		X
72 Adverse reaction to serum, drugs, medicine, food, or bites or stings		X
73 A weight problem		X
74 Recent gain or loss of weight		X
75 Excessive bleeding or easy bruising		X
76 Tumor, growth, cyst, or cancer		X
77 Considered or attempted suicide		X
78 Sleepwalking episodes		X
79 Easy fatigability		X
80 Car, train, sea, or air sickness	X	
81 X-ray or other radiation therapy		X
82 Sensitivity to chemicals, dust, sunlight, etc		X
83 Learning disabilities or speech problems		X
D. FEMALES ONLY – Have you ever N/A		
84 Been treated for a female disorder, painful periods, or cramps		
85 Had a change in menstrual pattern		
86 Been pregnant or are you now pregnant		
87 Taken birth control pills *(If yes, give dates and product names)*		

E. Have you ever	Yes	No
88 Been refused employment or been unable to hold a job or stay in school because of		X
a Inability to perform certain movements?		X
b Inability to assume certain positions?		X
c Other medical reasons?		X
89 Been rejected for or discharged from military service because of physical, mental or other reasons?		X
90 Been denied or rated up for life insurance?		X

E. (Contd.) Have you ever	Yes	No
91 Received, is there pending, or have you applied for pension or compensation for existing disability?		X
92 Had or have you ever been advised to have any surgical operations?		X
93 Consulted or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?		X
94 Had any illness or injury other than those already noted?		X

REMARKS *(Every "Yes" response in items 11 through 34 must be explained in the space below. Give dates and complete details including names of doctors and hospitals or clinics and the current status of the condition. Continue on a separate sheet and attach to this form if additional space is needed.)*

#21 Wears hard contact lenses.
#22 Allergies--grass, hay and dust.
#28 and 29 Concussion while playing football - knocked out. Seen in emergency room at Luke General Hospital, Lloyd NY, September 1982, Dr Jones.
#41 Treated for gingivitis in 1983. No problem since. Dr Fix, Main Street, Aspen CO.
#66 Flatfeet. Treated with orthotics when participating in sports. Seen by Dr Jones, Force MA - 1984.
#80 Car sickness in childhood. I've outgrown it. No treatment.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGNED
HARRY G. MORAY	Harry G. Moray	10 Dec 88

NOTE: HAND TO DOCTOR OR NURSE OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY"

EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Examiner shall comment on all "Yes" and blank answers (indicating the item number before each comment), develop by interview any additional medical history deemed important, and record significant findings here. If additional space is needed, continue on a separate sheet and attach to this form.)*

#21 Wear hard contact lenses. Lenses removed 22 days prior to exam.
#22 Allergic rhinitis during spring, treated with OTC medication, well controlled, NCNS.
#28 and 29 HX of concussion in 1986, LOC 2 minutes, skull x-rays negative, neurological evaluation, WNL, NCNS.
#41 Treated for givgivitis 1983. Resolved.
#66 Flatfoot, wears orthotics when participating in sports.
#80 Car sickness in childhood. No problem now.

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	SIGNATURE	DATE SIGNED	NUMBER OF ATTACHED SHEETS
J. D. GODIE, M. D.	J. D. Godie	15 Dec 88	

DD Form 2492 Reverse, MAR 87

DD FORM 2492, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY—FEMALE

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY
(This information is for official and medically confidential use only and will not be released to unauthorized persons)
(This form is subject to the Privacy Act of 1974 - See DD Form 2005)

Form Approved OMB No. 0704-0269 Expires Sep 30 1989

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	TELEPHONE NO. (Include area code)
MORAY LISA A.	011-11-0001	(102) 962-0001

PURPOSE OF EXAMINATION	EXAMINATION FACILITY OR EXAMINER AND ADDRESS (Include Zip Code)	DATE OF EXAMINATION
DODMERB	USAF CLINIC HANSCOM, HANSCOM FLD MA 01101	5 May 87

SECTION I – Mark applicable boxes in items 1 through 10

1. How would you rate your present health?
[X] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor

2. How many hours sleep do you usually get at night?
[ ] 4 or less [ ] 5 [ ] 6 [ ] 7 [X] 8 [ ] 9 or more

3. How many days per week do you exercise vigorously (enough to produce a sweat) **for at least fifteen minutes**
[ ] None [ ] 1 [ ] 2 [ ] 3 [X] 4 [ ] 5 [ ] 6 [ ] 7

4. Are you on any special diet?
[ ] Yes [X] No

5. Indicate the tobacco products you currently use.
[X] Cigarettes [ ] Cigars [ ] Chewing tobacco
[ ] Snuff (Smokeless tobacco) [ ] Pipes [ ] None (Skip to item 7)

6. If you smoke cigarettes how many do you smoke each day?
[X] Less than 1 pack [ ] 1 pack [ ] 1-1/2 packs [ ] 2 packs or more

7. On the average, how many times per week do you drink any alcoholic beverages such as beer, wine, or liquor?
[X] Never (Skip to item 9) [ ] Less than once [ ] Once or twice [ ] Three or four [ ] Five or more

8. When you drink, how many alcoholic drinks do you have (on the average)**?**
[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 or more

9. Have you ever used any of the following? N/A
[ ] Amphetamines [ ] Barbiturates [ ] Chemical inhalants
[ ] Cocaine [ ] Hallucinogens [ ] Narcotic drugs

10. What is your marital status?
[XX] Never Married [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

SECTION II – Mark each item *(11 through 94)* "Yes" or "No." If you do not know the answer for a particular item, leave it blank. Every item marked "Yes" must be explained in the REMARKS section on the reverse.

A. Does your family have a history of	Yes	No
11 Diabetes or sugar diabetes		X
12 Heart trouble or strokes		X
13 High blood pressure		X
14 Cancer		X
15 Mental condition		X
16 Alcoholism or suicide		X
17 Seizures or epilepsy		X
18 Allergies or Asthma		X
19 Arthritis or rheumatism		X
B. Do you or did you ever		
20 Wear glasses		X
21 Wear contact lenses or ocular eye retainers	X	
22 Have any allergies	X	
23 Take any medications regularly		X
24 Stutter or stammer		X
25 Wear a bone or joint brace or support		X
C. Have you ever had or do you now have		
26 Frequent, severe, or migraine headaches		X
27 Fainting or dizzy spells		X
28 Periods of unconsciousness	X	
29 Head injury or skull fracture	X	
30 Epilepsy, seizures, or convulsions		X
31 Loss of memory or amnesia		X
32 Depression, excessive worry or nervousness, anxiety		X
33 Any mental condition or illness		X
34 Frequent trouble sleeping		X

C. (Contd.) Have you ever had or do you now have	Yes	No
35 Eye trouble (*exclude glasses, contact lenses*)		X
36 Vision change or double vision		X
37 Hearing loss		X
38 Ear, nose, or throat trouble		X
39 Sinusitis or sinus trouble		X
40 Hay fever or allergic rhinitis		X
41 Severe tooth or gum trouble	X	
42 Thyroid trouble		X
43 Chronic cough or lung disease		X
44 Asthma or wheezing		X
45 Unusual shortness of breath		X
46 Pain or pressure in chest		X
47 Palpitation or pounding heart		X
48 Heart trouble or heart murmur		X
49 High blood pressure		X
50 Coughed up or vomited blood		X
51 Stomach, liver, or intestinal trouble		X
52 Gallbladder trouble or gallstones		X
53 Yellow jaundice or hepatitis		X
54 Hemorrhoids or rectal disease		X
55 Black or bloody stools		X
56 Frequent or painful urination		X
57 Bed wetting since age 12		X
58 Blood, protein, or sugar in urine		X
59 Kidney stone		X
60 Hernia or rupture		X
61 Any bone or joint trouble, bursitis		X
62 Broken bones or amputations		X
63 Steel pins, plates, or staples in any bones		X

C. (Contd.) Have you ever had or do you now have	Yes	No
64 Back pain or trouble		X
65 Paralysis, lameness, or weakness		X
66 Foot trouble	X	
67 Rheumatic fever		X
68 Tuberculosis or positive TB test		X
69 Homosexual activity		X
70 VD, syphilis, gonorrhea, herpes, etc		X
71 Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin		X
72 Adverse reaction to serum, drugs, medicine, food, or bites or stings		X
73 A weight problem		X
74 Recent gain or loss of weight		X
75 Excessive bleeding or easy bruising		X
76 Tumor, growth, cyst, or cancer		X
77 Considered or attempted suicide		X
78 Sleepwalking episodes		X
79 Easy fatigability		X
80 Car, train, sea, or air sickness	X	
81 X-ray or other radiation therapy		X
82 Sensitivity to chemicals, dust, sunlight, etc		X
83 Learning disabilities or speech problems		X
D. FEMALES ONLY – Have you ever		
84 Been treated for a female disorder, painful periods, or cramps		X
85 Had a change in menstrual pattern		X
86 Been pregnant or are you now pregnant		X
87 Taken birth control pills (*If yes, give dates and product names*)		X

E. Have you ever	Yes	No
88 Been refused employment or been unable to hold a job or stay in school because of:		X
a Inability to perform certain movements?		X
b Inability to assume certain positions?		X
c Other medical reasons?		X
89 Been rejected for or discharged from military service because of physical, mental or other reasons?		X
90 Been denied or rated up for life insurance?		X

E. (Contd.) Have you ever	Yes	No
91 Received, is there pending, or have you applied for pension or compensation for existing disability?		X
92 Had, or have you ever been advised to have, any surgical operations?		X
93 Consulted or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?		X
94 Had any illness or injury other than those already noted?		X

DoD Exception to SF93 approved by GSA/IRMS 2-87

REMARKS *(Every "Yes" response in items 11 through 94 must be explained in the space below. Give dates and complete details including names of doctors and hospitals or clinics and the current status of the condition. Continue on a separate sheet and attach to this form if additional space is needed.)*

#21 Wear soft contact lenses.
#22 Allergies--grass, hay and dust.
#28 and 29 Concussion while playing softball - knocked out. Seen in emergency room at George General Hospital, Rome NY, July 1985, Dr Henry.
#41 Treated for gingivitis in 1982. No problem now. Dr Gabelman, Elm Street, Vail CO.
#66 Flatfeet. Treated with orthotics when participating in sports. Seen by Dr Williams, Salem MA.
#80 Car sickness in childhood. I've outgrown it. No treatment.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGNED
LISA A. MORAY	Lisa A Moray	10 Dec 88

NOTE: HAND TO DOCTOR OR NURSE OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY"

EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Examiner shall comment on all "Yes" and blank answers (indicating the item number before each comment), develop by interview any additional medical history deemed important, and record significant findings here. If additional space is needed, continue on a separate sheet and attach to this form.)*

#21 Wear soft contact lenses. Lenses removed 22 days prior to exam.
#22 Allergic rhinitis during spring, treated with OTC medications, well controlled, NCNS.
#28 and 29 HX of concussion in 1986, LOC 2 minutes, skull x-rays negative, neurological evaluation, WNL, NCNS.
#41 Treated for Gingivitis 1982, resolved.
#66 Flatfeet. Wears orthotics when participating in sports.
#80 Car sickness in childhood. No problem now.

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	SIGNATURE	DATE SIGNED	NUMBER OF ATTACHED SHEETS
JOHN J. SMITH, M. D.	John J. Smith	15 Dec 88	

DD Form 2492 Reverse, MAR 87

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF MEDICAL HISTORY
(This information is for official and medically confidential use only and will not be released to unauthorized persons.)
(This form is subject to the Privacy Act of 1974 - See DD Form 2005)

Form Approved
OMB No. 0704-0269
Expires Sep 30, 1989

NAME (Last, First, Middle Initial)	SOCIAL SECURITY NUMBER	TELEPHONE NO. (Include area code)

PURPOSE OF EXAMINATION	EXAMINATION FACILITY OR EXAMINER AND ADDRESS (Include Zip Code)	DATE OF EXAMINATION

SECTION I – Mark applicable boxes in items 1 through 10

1. How would you rate your present health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How many hours sleep do you usually get at night?
☐ 4 or less ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 or more

3. How many days per week do you exercise vigorously *(enough to produce a sweat)* **for at least fifteen minutes**
☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

4. Are you on any special diet?
☐ Yes ☐ No

5. Indicate the tobacco products you currently use.
☐ Cigarettes ☐ Cigars ☐ Chewing tobacco
☐ Snuff (Smokeless tobacco) ☐ Pipes ☐ None *(Skip to item 7)*

6. If you smoke cigarettes how many do you smoke each day?
☐ Less than 1 pack ☐ 1 pack ☐ 1-1/2 packs ☐ 2 packs or more

7. On the average, how many times per week do you drink any alcoholic beverages such as beer, wine, or liquor?
☐ Never *(skip to item 9)* ☐ Less than once ☐ Once or twice ☐ Three or four ☐ Five or more

8. When you drink, how many alcoholic drinks do you have *(on the average)*?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

9. Have you ever used any of the following?
☐ Amphetamines ☐ Barbiturates ☐ Chemical inhalants
☐ Cocaine ☐ Hallucinogens ☐ Narcotic drugs

10. What is your marital status?
☐ Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

SECTION II – Mark each item *(11 through 94)* "Yes" or "No". If you do not know the answer for a particular item, leave it blank. Every item marked "Yes" must be explained in the REMARKS section on the reverse.

A. Does your family have a history of	Yes	No
11 Diabetes or sugar diabetes		
12 Heart trouble or strokes		
13 High blood pressure		
14 Cancer		
15 Mental condition		
16 Alcoholism or suicide		
17 Seizures or epilepsy		
18 Allergies or Asthma		
19 Arthritis or rheumatism		
B. Do you or did you ever		
20 Wear glasses		
21 Wear contact lenses or ocular eye retainers		
22 Have any allergies		
23 Take any medications regularly		
24 Stutter or stammer		
25 Wear a bone or joint brace or support		
C. Have you ever had or do you now have		
26 Frequent, severe, or migraine headaches		
27 Fainting or dizzy spells		
28 Periods of unconsciousness		
29 Head injury or skull fracture		
30 Epilepsy, seizures, or convulsions		
31 Loss of memory or amnesia		
32 Depression, excessive worry or nervousness, anxiety		
33 Any mental condition or illness		
34 Frequent trouble sleeping		

C. (Contd.) Have you ever had or do you now have	Yes	No
35 Eye trouble *(exclude glasses, contact lenses)*		
36 Vision change or double vision		
37 Hearing loss		
38 Ear, nose, or throat trouble		
39 Sinusitis or sinus trouble		
40 Hay fever or allergic rhinitis		
41 Severe tooth or gum trouble		
42 Thyroid trouble		
43 Chronic cough or lung disease		
44 Asthma or wheezing		
45 Unusual shortness of breath		
46 Pain or pressure in chest		
47 Palpitation or pounding heart		
48 Heart trouble or heart murmur		
49 High blood pressure		
50 Coughed up or vomited blood		
51 Stomach, liver, or intestinal trouble		
52 Gallbladder trouble or gallstones		
53 Yellow jaundice or hepatitis		
54 Hemorrhoids or rectal disease		
55 Black or bloody stools		
56 Frequent or painful urination		
57 Bed wetting since age 12		
58 Blood, protein, or sugar in urine		
59 Kidney stone		
60 Hernia or rupture		
61 Any bone or joint trouble, bursitis		
62 Broken bones or amputations		
63 Steel pins, plates, or staples in any bones		

C. (Contd.) Have you ever had or do you now have	Yes	No
64 Back pain or trouble		
65 Paralysis, lameness, or weakness		
66 Foot trouble		
67 Rheumatic fever		
68 Tuberculosis or positive TB test		
69 Homosexual activity		
70 VD, syphilis, gonorrhea, herpes, etc		
71 Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin		
72 Adverse reaction to serum, drugs, medicine, food, or bites or stings		
73 A weight problem		
74 Recent gain or loss of weight		
75 Excessive bleeding or easy bruising		
76 Tumor, growth, cyst, or cancer		
77 Considered or attempted suicide		
78 Sleepwalking episodes		
79 Easy fatigability		
80 Car, train, sea, or air sickness		
81 X-ray or other radiation therapy		
82 Sensitivity to chemicals, dust, sunlight, etc.		
83 Learning disabilities or speech problems		
D. FEMALES ONLY – Have you ever		
84 Been treated for a female disorder, painful periods, or cramps		
85 Had a change in menstrual pattern		
86 Been pregnant or are you now pregnant		
87 Taken birth control pills *(If yes, give dates and product names)*		

E. Have you ever	Yes	No
88 Been refused employment or been unable to hold a job or stay in school because of:		
a Inability to perform certain movements?		
b Inability to assume certain positions?		
c Other medical reasons?		
89 Been rejected for or discharged from military service because of physical, mental or other reasons?		
90 Been denied or rated up for life insurance?		

E. (Contd.) Have you ever	Yes	No
91 Received, is there pending, or have you applied for pension or compensation for existing disability?		
92 Had, or have you ever been advised to have, any surgical operations?		
93 Consulted or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?		
94 Had any illness or injury other than those already noted?		

REMARKS *(Every "Yes" response in items 11 through 94 must be explained in the space below. Give dates and complete details including names of doctors and hospitals or clinics and the present status of the condition. Continue on a separate sheet and attach to this form if additional space is needed.)*

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGNED

NOTE: HAND TO DOCTOR OR NURSE OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY"

EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Examiner shall comment on all "Yes" and blank answers (indicating the item number before each comment), develop by interview any additional medical history deemed important, and record significant findings here. If additional space is needed, continue on a separate sheet and attach to this form.)*

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	SIGNATURE	DATE SIGNED	NUMBER OF ATTACHED SHEETS

DD Form 2492 Reverse, MAR 87

DD FORM 2480, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION

Privacy Act Statement

AUTHORITY: 10 USC 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: Used to determine medical acceptability for one or more of the Service Academies, ROTC, or USUHS, Information will be released to authorized personnel involved in the selection process. The Social Security Number (SSN) is used for positive identification.

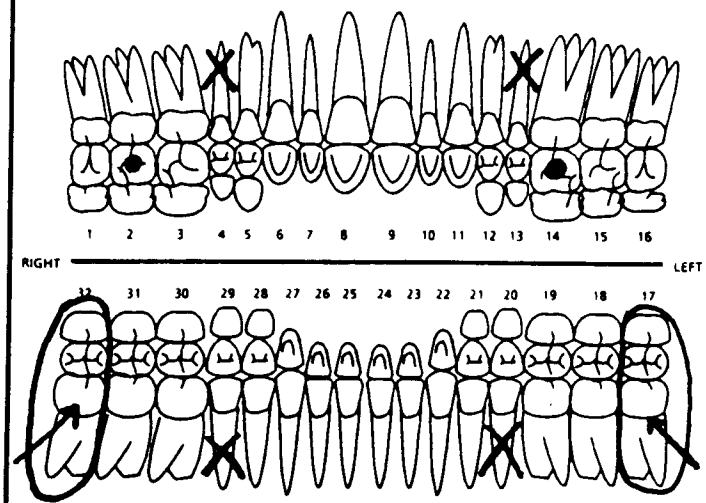
DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. APPLICANT'S NAME (Last, First, Middle Initial)	2. SSN
JONES, HARRY W., JR.	100-01-0001

INSTRUCTIONS

To be completed at scheduled Examining Center by the Examining Dentist. Panoramic and bitewing radiographs must accompany this examination and be identified by name and SSN. Expedite completed Dental Examination with completed Medical Examination to: DODMERB/DB, US Academy, Colorado Springs, Co 80840-6518.

3. INDICATE ON THE CHART BELOW, RESTORABLE, NON-RESTORABLE, MISSING TEETH, TEETH REPLACED, SPACES CLOSED AND ANY DEFECTS OR ABNORMALITIES. *(Do not chart restorations)*



4. TYPED OR PRINTED NAME OF EXAMINING DENTIST
MARK V. ALLEN, D.D.S.

5. SIGNATURE OF EXAMINING DENTIST
Mark V. Allen

6. DATE SIGNED
6 Jan 89

7. EXAMINING FACILITY

a. NAME
Vandenberg Dental Clinic

b. ADDRESS
USAF Clinic/SGD
Vandenberg AFB CA 93437-5300

NOTE If examinee has a questionable occlusal relationship, forward diagnostic casts to:
DODMERB/D8
US Academy
Colorado Springs, CO 80840-6518

8. GENERAL *("X" Yes or No for each question)*

YES	NO	
X		a. DENTAL CARIES *(Indicate on chart, do not chart incipiencies)*
X		b. MISSING TEETH, OTHER THAN THIRD MOLARS *(Indicate on chart by marking "X" through the roots)*
	X	c. NON-RESTORABLE TEETH *(Indicate on chart by drawing two vertical lines through tooth)*
X		d. UNERUPTED TEETH *(Draw circle around the tooth on the chart and indicate position by an arrow).*
	X	e. DEVELOPMENTAL DISTURBANCES IN TEETH *(Significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.).*
	X	f. STAINED TEETH *(Intrinsic) (unsightly).*

9. HISTORY OF ORAL DISEASE, TUMOR OR ANY OTHER ABNORMALITY OF THE ORAL CAVITY
("X" Yes or No for each question. If additional space is needed use "REMARKS" section.)

	X	a. HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS? *(If so, describe.)*
	X	b. HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES. *(Describe)*
	X	c. ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. *(Describe)*
	X	d. HISTORY OF CLEFT LIP
	X	e. HISTORY OF CLEFT PALATE.
	X	(1) If yes, is there an oro-nasal or oro-antral fistula present?
	X	f. HISTORY OF TMJ DISEASE OR PAIN. *(Describe)*

(Continued on reverse side)

YES	NO	
	X	**10. OCCLUSAL RELATIONSHIP** *("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)* a. ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm
	X	b. ANTERIOR OVERBITE IN EXCESS OF 4mm
	X	c. ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4mm.
	X	d. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIOR TEETH INTO THE LOWER LABIAL GINGIVAE.
	X	e. ANTERIOR CROSSBITE. *(Describe)*
	X	f. MANDIBULAR PROGNATHISM.
	X	g. POSTERIOR OPEN BITE *(bilateral involving more than one tooth)*
	X	h. POSTERIOR CROSSBITE *(entire quadrant)*
	X	i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH
	X	j. MULTIPLE CONGENITALLY MISSING TEETH.
X		k. MIDLINE DEVIATION. 2 mm
	X	l. ARE DENTAL STUDY CASTS BEING FORWARDED?
		11. ORTHODONTICS *("X" Yes or No for each question)*
X		a. PAST HISTORY OF ORTHODONTIC TREATMENT *(date completed)* June 87
	X	b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT *(specify fixed or removable)*
X		c. WEARING RETAINER APPLIANCES. 21 thru 27 fixed retainer
		12. PROSTHODONTICS *("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section.)*
	X	a. MISSING TEETH *(prosthesis required). (Describe)*
	X	b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS *(Describe)*
	X	c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?
		13. PERIODONTAL STATUS *("X" Yes or No for each question)*
	X	a. MODERATE TO HEAVY CALCULUS *(supra and or sub-gingival)*
	X	b. GINGIVITIS *(generalized)*
	X	c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS
	X	d. LOCAL OR GENERALIZED PERIODONTITIS *(with associated bone loss).*
	X	e. JUVENILE PERIODONTITIS.
	X	f. PERICORONITIS.
		14. PANOGRAPHIC RADIOGRAPH EXAMINATION *("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)*
	X	a. ABNORMAL RADIOLUCENT/RADIOPAQUE AREA. *(Describe)*
	X	b. IMPACTED TEETH WITH PATHOLOGY. *(Describe)*
	X	c. IMPACTED TEETH OTHER THAN THIRD MOLARS *(Describe)*
	X	d. OTHER RADIOGRAPHIC ABNORMALITIES. *(Describe)*
		15. OTHER ABNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED. *("X" Yes or No)*
	X	

16. REMARKS *(Indicate item of reference.) (Use additional sheet if necessary.)*

13a Patient needs prophylaxis and scaling.

DODMERB USE ONLY

DD Form 2480 Reverse, NOV 86

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
REPORT OF DENTAL EXAMINATION

Privacy Act Statement

AUTHORITY: 10 USC 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: Used to determine medical acceptability for one or more of the Service Academies, ROTC, or USUHS, Information will be released to authorized personnel involved in the selection process. The Social Security Number (SSN) is used for positive identification.

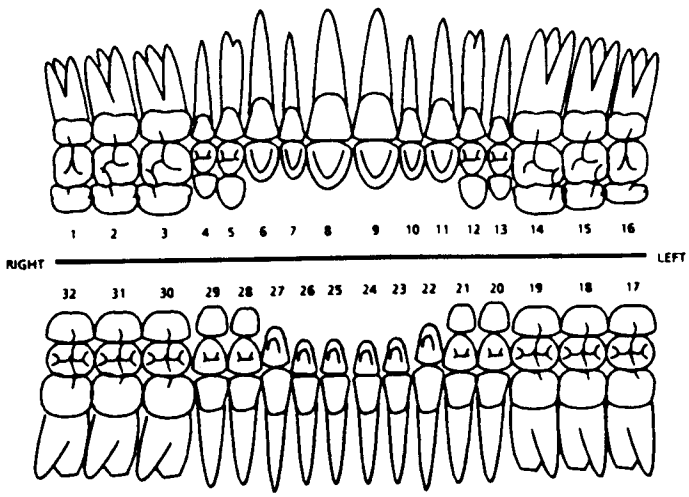
DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. APPLICANT'S NAME *(Last, First, Middle Initial)*	2. SSN

INSTRUCTIONS

To be completed at scheduled Examining Center by the Examining Dentist. Panoramic and bitewing radiographs must accompany this examination and be identified by name and SSN. Expedite completed Dental Examination with completed Medical Examination to: DODMERB/DB, US Academy, Colorado Springs, Co 80840-6518.

3. INDICATE ON THE CHART BELOW, RESTORABLE, NON-RESTORABLE, MISSING TEETH, TEETH REPLACED, SPACES CLOSED AND ANY DEFECTS OR ABNORMALITIES. *(Do not chart restorations)*



4. TYPED OR PRINTED NAME OF EXAMINING DENTIST

5. SIGNATURE OF EXAMINING DENTIST	6. DATE SIGNED

7. EXAMINING FACILITY

a. NAME

b. ADDRESS

NOTE If examinee has a questionable occlusal relationship, forward diagnostic casts to

DODMERB/DB
US Academy
Colorado Springs, CO 80840-6518

8. GENERAL *("X" Yes or No for each question)*

YES	NO	
		a. DENTAL CARIES *(Indicate on chart, do not chart incipences).*
		b. MISSING TEETH, OTHER THAN THIRD MOLARS *(Indicate on chart by marking "X" through the roots).*
		c. NON-RESTORABLE TEETH *(Indicate on chart by drawing two vertical lines through tooth).*
		d. UNERUPTED TEETH *(draw circle around the tooth on the chart and indicate position by an arrow).*
		e. DEVELOPMENTAL DISTURBANCES IN TEETH *(significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.).*
		f. STAINED TEETH *(Intrinsic) (unsightly).*

9. HISTORY OF ORAL DISEASE, TUMOR OR ANY OTHER ABNORMALITY OF THE ORAL CAVITY
("X" Yes or No for each question. If additional space is needed use "REMARKS" section.)

		a. HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS? *(If so, describe.)*
		b. HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES. *(Describe)*
		c. ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. *(Describe)*
		d. HISTORY OF CLEFT LIP
		e. HISTORY OF CLEFT PALATE.
		(1) If yes, is there an oro-nasal or oro-antral fistula present?
		f. HISTORY OF TMJ DISEASE OR PAIN. *(Describe)*

(Continued on reverse side)

YES	NO	
		10. OCCLUSAL RELATIONSHIP *("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section)*
		a. ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm
		b. ANTERIOR OVERBITE IN EXCESS OF 4mm
		c. ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4mm.
		d. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIOR TEETH INTO THE LOWER LABIAL GINGIVAE
		e. ANTERIOR CROSSBITE. *(Describe)*
		f. MANDIBULAR PROGNATHISM.
		g. POSTERIOR OPEN BITE *(bilateral involving more than one tooth).*
		h. POSTERIOR CROSSBITE *(entire quadrant)*
		i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH
		j. MULTIPLE CONGENITALLY MISSING TEETH
		k. MIDLINE DEVIATION.
		l. ARE DENTAL STUDY CASTS BEING FORWARDED?
		11. ORTHODONTICS *("X" Yes or No for each question)*
		a. PAST HISTORY OF ORTHODONTIC TREATMENT *(date completed).*
		b. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT *(specify fixed or removable).*
		c. WEARING RETAINER APPLIANCES.
		12. PROSTHODONTICS *("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section.)*
		a. MISSING TEETH *(prosthesis required) (Describe)*
		b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS *(Describe)*
		c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?
		13. PERIODONTAL STATUS *("X" Yes or No for each question)*
		a. MODERATE TO HEAVY CALCULUS *(supra and / or sub-gingival)*
		b. GINGIVITIS *(generalized).*
		c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS
		d. LOCAL OR GENERALIZED PERIODONTITIS *(with associated bone loss).*
		e. JUVENILE PERIODONTITIS.
		f. PERICORONITIS.
		14. PANOGRAPHIC RADIOGRAPH EXAMINATION *("X" Yes or No for each question) (If additional space is needed, use "REMARKS" section).*
		a. ABNORMAL RADIOLUCENT / RADIOPAQUE AREA. *(Describe)*
		b. IMPACTED TEETH WITH PATHOLOGY. *(Describe)*
		c. IMPACTED TEETH OTHER THAN THIRD MOLARS. *(Describe)*
		d. OTHER RADIOGRAPHIC ABNORMALITIES. *(Describe)*
		15. OTHER ABNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED. *("X" Yes or No)*

16. REMARKS *(Indicate item of reference.) (Use additional sheet if necessary.)*

DODMERB USE ONLY

DD Form 2480 Reverse, NOV 86

ITEM-BY-ITEM EXPLANATION FOR FILLING OUT DD FORM 2480

Explanation	Model Entry
Item 1. Applicant Name. (Last, First, MI)	Jones, Harry W., Jr.
Item 2. Social Security Number.	999-99-9999
Item 3. Indicate on the chart: Restorable, nonrestorable, missing teeth, teeth replaced, spaces closed and any defects or abnormalities. Do not chart restorations.	See item 3, attachment 4
Item 4. Typed or Printed Name of Examining Dentist.	CHARLES P. WHITE, Maj, USAF, DC
Items 5 and 6. Signature of Examining Dentist and Date of Dental Examination.	Self-explanatory
Item 7. Examining Facility and Address.	USAF Clinic/SGD Vandenberg AFB CA 93437-5300
Items 8 through 15. A yes or no answer is required for each of the questions. Write in additional information next to the question or in the remarks section (item 16).	See items 8 through 15, attachment 4
Item 16. Remarks. Indicate item of reference, use additional sheet if necessary.	Item 13a. Patient needs prophylaxis and scaling.

DD FORM 2369, DOD MEDICAL EXAMINATION REVIEW BOARD CYCLOPEGIC REFRACTION

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
CYCLOPLEGIC REFRACTION

Privacy Act Statement

AUTHORITY: Title 10, USC 122, and Executive Order 9397.

PRINCIPAL PURPOSE: To upgrade a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USE: To determine medical acceptability for one or more of the service academies, ROTC OR USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary, however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. DATE OF EXAMINATION
SCARBOROUGH, JIMMY R	001-00-1000	5 May 87

4. ADDRESS OF FACILITY (City, State, Zip Code)	5. PHONE NO. AT FACILITY (Include Area Code)
USAFA HOSPITAL/SGP USAFA, CO 80840	(303) 472-3577

6. CONTACT LENS DATA (X Applicable Item(s))

X	a. I do not wear contact lenses	
	b. Soft contact lenses were removed	days prior to the above examination
	c. Hard contact lenses were removed	days prior to the above examination
	d. Signature of Applicant	

7. FAMILY EYE HISTORY (Please indicate the members of your immediate family who wear glasses or contact lenses.) (X applicable item(s))

X	a. Father
	b. Mother
	c. Brother
X	d. Sister
	e. None of my family

8. VISION EVALUATION BEFORE INSTALLATION OF DROPS (Before cycloplegic)

a. DISTANT VISION		b. CURRENT RX N/A		
OD 20/ 20	Corr to 20/	OD Sphere	Cyl	Axis
OS 20/ 20	Corr to 20/	OS Sphere	Cyl	Axis
c. NEAR VISION		**9. MEDICATION USED FOR CYCLOPLEGIC**		
OD 20/ 20	Corr to 20/	Cyclogel		
OS 20/ 20	Corr to 20/			

10. VISION EVALUATION AFTER CYCLOPLEGIA OBTAINED (NOTE Correct to 20/20 absolute Record number of letters missed on 20/20, i.e., 20/20-2, 20/20-3 etc. If unable to correct to 20/20, record best correctable vision Do not over correct, correct only to 20/20)

a. DISTANT VISION CORRECTED TO		b. CYCLO RX			
OD 20/ 50	Corr to 20/ 15	OD Sphere +0.50	Cyl -0.50	Axis 088	
OS 20/ 50	Corr to 20/ 15	OS Sphere +0.50	Cyl -0.25	Axis 090	

11. REMARKS (Examiner should list any diagnosis which interferes with visual function which was noted on this examination)

12. TYPED OR PRINTED NAME OF EXAMINER	13. SIGNATURE OF EXAMINER
ISSAC L. DOETOE, CAPT, USAF, BSC	Issac L. Doetoe, Capt, USAF

DD Form 2369, MAY 86 *Previous edition will be used*

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

CYCLOPLEGIC REFRACTION

Privacy Act Statement

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1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. DATE OF EXAMINATION

4. ADDRESS OF FACILITY (City, State, Zip Code)	5. PHONE NO. AT FACILITY (Include Area Code)

6. CONTACT LENS DATA (X Applicable Item(s))

	a. I do not wear contact lenses	
	b. Soft contact lenses were removed	days prior to the above examination
	c. Hard contact lenses were removed	days prior to the above examination
	d. Signature of Applicant	

7. FAMILY EYE HISTORY (Please indicate the members of your immediate family who wear glasses or contact lenses.) (X applicable item(s))

	a. Father
	b. Mother
	c. Brother
	d. Sister
	e. None of my family

8. VISION EVALUATION BEFORE INSTALLATION OF DROPS (Before cycloplegic)

a. DISTANT VISION		b. CURRENT RX		
OD 20/	Corr to 20/	OD Sphere	Cyl	Axis
OS 20/	Corr to 20/	OS Sphere	Cyl	Axis
c. NEAR VISION		**9. MEDICATION USED FOR CYCLOPLEGIC**		
OD 20/	Corr to 20/			
OS 20/	Corr to 20/			

10. VISION EVALUATION AFTER CYCLOPLEGIA OBTAINED (NOTE: Correct to 20/20 absolute. Record number of letters missed on 20/20, i.e., 20/20-2, 20/20-3 etc. If unable to correct to 20/20, record best correctable vision. Do not over correct, correct only to 20/20.)

a. DISTANT VISION CORRECTED TO		b. CYCLO RX		
OD 20/	Corr to 20/	OD Sphere	Cyl	Axis
OS 20/	Corr to 20/	OS Sphere	Cyl	Axis

11. REMARKS (Examiner should list any diagnosis which interferes with visual function which was noted on this examination.)

12. TYPED OR PRINTED NAME OF EXAMINER	13. SIGNATURE OF EXAMINER

DD Form 2369, MAY 86 *Previous edition will be used.*

DD FORM 2370, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) THREE-DAY BLOOD PRESSURE AND PULSE CHECK

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

THREE DAY BLOOD PRESSURE AND PULSE CHECK

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT
MARTINEZ CATHERINE L	512-10-0000

INSTRUCTIONS TO EXAMINERS

Studies have shown that the sphygmomanometer cuff must be the correct width for the circumference of the patient's arm. If it is too narrow, the blood pressure readings will be erroneously high. If it is too wide, the readings may be erroneously low. For the average adult, a cuff 12 to 14 cm wide is satisfactory. For arm circumference greater than 28 cm a larger cuff, 18 to 20 cm wide, must be used.

3. ARM CIRCUMFERENCE	4. WIDTH OF THE BLOOD PRESSURE CUFF	5. MEDICATION CURRENTLY TAKEN (If none, so state)
9"	14 cm	NONE

6. BLOOD PRESSURE AND PULSE READINGS

a. DAY ONE

(1) DATE	(2) A.M. 0700		(3) P.M. 1300	
5 May 87	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING	136/80	80	140/86	88
(b) RECUMBENT	138/78	78	130/80	80
(c) STANDING	130/80	78	138/82	8

b. DAY TWO

(1) DATE	(2) A.M. 0715		(3) P.M. 1400	
6 May 87	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING	120/80	80	130/70	76
(b) RECUMBENT	120/76	76	126/70	76
(c) STANDING	126/82	80	132/80	80

c. DAY THREE

(1) DATE	(2) A.M. 0730		(3) P.M. 1500	
7 May 87	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING	120/76	76	130/80	76
(b) RECUMBENT	118/80	76	130/80	74
(c) STANDING	124/80	80	136/86	80

7. EXAMINER (Doctor/Nurse/Paramedical Technician)

a. TYPED OR PRINTED NAME (Last, First, Middle Initial)	b. SIGNATURE
MEDIC, JOHNNY D	Johnny D Medic
c. TITLE AIC, Blood Pressure Recheck Department	

DD Form 2370, MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

THREE DAY BLOOD PRESSURE AND PULSE CHECK

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT

INSTRUCTIONS TO EXAMINERS

Studies have shown that the sphygmomanometer cuff must be the correct width for the circumference of the patient's arm. If it is too narrow, the blood pressure readings will be erroneously high. If it is too wide, the readings may be erroneously low. For the average adult, a cuff 12 to 14 cm wide is satisfactory. For arm circumference greater than 28 cm a larger cuff, 18 to 20 cm wide, must be used.

3. ARM CIRCUMFERENCE	4. WIDTH OF THE BLOOD PRESSURE CUFF	5. MEDICATION CURRENTLY TAKEN (If none, so state.)

6. BLOOD PRESSURE AND PULSE READINGS

a. DAY ONE

(1) DATE	(2) A.M.		(3) P.M.	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING				
(b) RECUMBENT				
(c) STANDING				

b. DAY TWO

(1) DATE	(2) A.M.		(3) P.M.	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING				
(b) RECUMBENT				
(c) STANDING				

c. DAY THREE

(1) DATE	(2) A.M.		(3) P.M.	
	BLOOD PRESSURE	PULSE	BLOOD PRESSURE	PULSE
(a) SITTING				
(b) RECUMBENT				
(c) STANDING				

7. EXAMINER (Doctor/Nurse/Paramedical Technician)

a. TYPED OR PRINTED NAME (Last, First, Middle Initial)	b. SIGNATURE

c. TITLE

DD Form 2370, MAY 85

DD FORM 2371, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) UPDATE OF APPLICANT'S MEDICAL EXAMINATION

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
UPDATE OF APPLICANT'S MEDICAL EXAMINATION

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To upgrade a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USE: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. TYPED OR PRINTED NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. NAME OF PROGRAM APPLIED FOR
LEWIS, JOHN D.	001-01-1001	US Naval Academy

INSTRUCTIONS

The Department of Defense Medical Examination Review Board (DODMERB) has been requested to update your Service Academy medical examination report. Our records indicate that you were given a medical examination for last year's selection cycle. If there has been no change in your medical or dental condition, we may be able to use your previous examination report as the basis for determining your medical or dental status for the current selection cycle.

4. "I hereby certify that I have not received any medical or dental care since the date of my Service Academy medical examination."

a. The above statement *(X one)*

	(1) **IS TRUE AND ACCURATE** in all respects.
XX	(2) **IS NOT TOTALLY ACCURATE** *(Explain in detail in 4b below.)*

b. Detailed explanation why the statement in 4 above is not totally accurate *(Attach additional pages, if necessary.)*

I had two wisdom teeth removed in Jan 86. I had arthoscopic surgery on my right knee in Nov 85. My knee is fine now.

5. SIGNATURE OF APPLICANT	6. DATE SIGNED
John D Lewis	6 May 87

DD Form 2371 MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

UPDATE OF APPLICANT'S MEDICAL EXAMINATION

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To upgrade a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

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1. TYPED OR PRINTED NAME OF APPLICANT *(Last, First, Middle Initial)*	2. SSN OF APPLICANT	3. NAME OF PROGRAM APPLIED FOR

INSTRUCTIONS

The Department of Defense Medical Examination Review Board (DODMERB) has been requested to update your Service Academy medical examination report. Our records indicate that you were given a medical examination for last year's selection cycle. If there has been no change in your medical or dental condition, we may be able to use your previous examination report as the basis for determining your medical or dental status for the current selection cycle.

4. **"I hereby certify that I have not received any medical or dental care since the date of my Service Academy medical examination."**

a. The above statement *(X one)*

	(1) **IS TRUE AND ACCURATE** in all respects.
	(2) **IS NOT TOTALLY ACCURATE** *(Explain in detail in 4b below.)*

b. Detailed explanation why the statement in 4 above is not totally accurate *(Attach additional pages, if necessary.)*

5. SIGNATURE OF APPLICANT	6. DATE SIGNED

DD Form 2371 MAY 85

DD FORM 2372, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF PRESENT HEALTH

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
STATEMENT OF PRESENT HEALTH

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

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1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT
STEWART, ANN M.	001-02-1002

3. STATEMENT OF PRESENT HEALTH

Good.

4. NAME OF MEDICATION(S) AND REASON FOR TAKING *(If you are not on any kind of medications, simply state "NONE")*

Tetracycline for my acne.

5. DO YOU HAVE ALLERGIES? *(Answer Yes or No. If yes, indicate treatment received; if no allergies, write "NONE")*

6. REMARKS

7. SIGNATURE OF APPLICANT	8. DATE SIGNED
Ann M. Stewart	6 May 87

DD Form 2372, FEB 86 *Previous edition may be used.*

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF PRESENT HEALTH

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

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1. NAME OF APPLICANT *(Last, First, Middle Initial)*	2. SSN OF APPLICANT

3. STATEMENT OF PRESENT HEALTH

4. NAME OF MEDICATION(S) AND REASON FOR TAKING *(If you are not on any kind of medications, simply state "NONE ")*

5. DO YOU HAVE ALLERGIES? *(Answer Yes or No. If yes, indicate treatment received. If no allergies, write "NONE ")*

6. REMARKS

7. SIGNATURE OF APPLICANT	8. DATE SIGNED

DD Form 2372, FEB 86 *Previous edition may be used.*

DD FORM 2374, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) HEART MURMUR EVALUATION

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
HEART MURMUR EVALUATION

Privacy Act Statement

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1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT
MALIK, BONITA A	111-11-1111

INSTRUCTIONS TO EXAMINER

Conditions such as mitral valve prolapse and bicuspid aortic valve are being found increasingly even in the presence of "innocent" or "functional" murmurs. We request that you complete this form which will enable the Department of Defense Medical Examination Review Board to make a proper determination of the applicant's cardiac status.

3. GRADE, AMPLITUDE OR INTENSITY (Use the I-VI Scale)	4. LOCATION (Where is the sound heard best?)
Grade I/VI Systolic Murmur	Apex

5. TIMING DURING THE CARDIAC CYCLE (e.g., mid-systole)
Mid Systolic

6. CHARACTER OF THE SOUND (e.g., crescendo-decrescendo)
Decresendo

7. RADIATION OR TRANSMISSION OF THE SOUND
None

8. OTHER SOUNDS (e.g., click)
Mid Systolic Click

9. RESULT OF ECHOCARDIOGRAM (Please attach results - NOT TRACINGS.)
Mitral Valve Prolapse, minimal
DOPPLER: No evidence of mitral regurgitation

10. FINAL IMPRESSION AND OTHER COMMENTS
Innocent murmur by P.E. and by echo.

11. EXAMINING PHYSICIAN

a. TYPED OR PRINTED NAME (Last, First, Middle Initial)	b. SIGNATURE	c. DATE SIGNED
Lowe, John E		7 May 87

DD Form 2374, MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

HEART MURMUR EVALUATION

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

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1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT

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Conditions such as mitral valve prolapse and bicuspid aortic valve are being found increasingly even in the presence of "innocent" or "functional" murmurs. We request that you complete this form which will enable the Department of Defense Medical Examination Review Board to make a proper determination of the applicant's cardiac status.

3. GRADE, AMPLITUDE OR INTENSITY (Use the I-VI Scale)	4. LOCATION (Where is the sound heard best?)

5. TIMING DURING THE CARDIAC CYCLE (e.g., mid-systole)

6. CHARACTER OF THE SOUND (e.g., crescendo-decrescendo)

7. RADIATION OR TRANSMISSION OF THE SOUND

8. OTHER SOUNDS (e.g., click)

9. RESULT OF ECHOCARDIOGRAM (Please attach results - NOT TRACINGS.)

10. FINAL IMPRESSION AND OTHER COMMENTS

11. EXAMINING PHYSICIAN

a. TYPED OR PRINTED NAME (Last, First, Middle Initial)	b. SIGNATURE	c. DATE SIGNED

DD Form 2374, MAY 85

DD FORM 2375, DOD MEDICAL EXAMINATION REVIEW BOARD
(DODMERB) PULMONARY FUNCTION STUDIES

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

PULMONARY FUNCTION STUDIES

Privacy Act Statement

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1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. DATE OF EXAMINATION
DOE, JOHN E	000-00-0001	7 May 87

4. PRIOR TO EXERCISING, PROVIDE THE RESULTS OF A BLOOD AMINOPHYLLINE/ THEOPHYLLINE TEST	5. SPECIFIC REFERENCE TO THE STANDARD USED FOR NORMAL
Theophylline level: 0 ng/ml	Normal therapeutic range 10-20 ng/ml

6. VIGOROUS EXERCISE TO CONSIST OF 8 TO 10 MINUTES OF RUNNING. THIS EXERCISE MAY BE ACCOMPLISHED ON A TREADMILL. PERFORM THE FUNCTION TEST IMMEDIATELY UPON CESSATION OF THE EXERCISE. STATE DURATION OF EXERCISE →	10 mins	*NOTE: Administer the bronchodilator 4 minutes after exercise and perform the function test one minute thereafter.*

TEST RESULTS

	a. BEFORE EXERCISE		b. AFTER EXERCISE		c. AFTER BRONCHODILATOR	
	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)
7. TOTAL VITAL CAPACITY	4.50	89%	4.30	85%	4.55	90%
8. FEV-1.0	3.97	94%	3.73	89%	4.08	97%
9. MEFR 25-75 %	4.42	87%	3.99	78%	5.01	98%

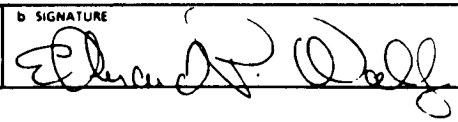
10. WAS WHEEZING PRESENT	YES	NO
a. BEFORE EXERCISE		X
b. AFTER EXERCISE		X
c. AFTER BRONCHODILATOR		X

11. IS THE PATIENT TAKING ANY MEDICATIONS? *(X one)*

	a. YES *(Specify medications and usage)*
XX	b. NO

12. EXAMINER

a. TYPED OR PRINTED NAME (Last, First, Middle Initial): Wally, Edward P

b. SIGNATURE: 

c. TITLE: Chief, Pulmonary Clinic, WBAMC, EP, TX

DD Form 2375, MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
PULMONARY FUNCTION STUDIES

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

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1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT	3. DATE OF EXAMINATION

4. PRIOR TO EXERCISING, PROVIDE THE RESULTS OF A BLOOD AMINOPHYLLINE/ THEOPHYLLINE TEST	5. SPECIFIC REFERENCE TO THE STANDARD USED FOR NORMAL

6. VIGOROUS EXERCISE TO CONSIST OF 8 TO 10 MINUTES OF RUNNING. THIS EXERCISE MAY BE ACCOMPLISHED ON A TREADMILL. PERFORM THE FUNCTION TEST IMMEDIATELY UPON CESSATION OF THE EXERCISE. STATE DURATION OF EXERCISE →

NOTE: Administer the bronchodilator 4 minutes after exercise and perform the function test one minute thereafter

TEST RESULTS

	a. BEFORE EXERCISE		b. AFTER EXERCISE		c. AFTER BRONCHODILATOR	
	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)	NORMAL (1)	% PREDICTED (2)
7. TOTAL VITAL CAPACITY						
8. FEV - 1.0						
9. MEFR 25 - 75 %						

10. WAS WHEEZING PRESENT	YES	NO
a. BEFORE EXERCISE		
b. AFTER EXERCISE		
c. AFTER BRONCHODILATOR		

11. IS THE PATIENT TAKING ANY MEDICATIONS? *(X one)*

☐ a. YES *(Specify medications and usage)*

☐ b. NO

12. EXAMINER	
a. TYPED OR PRINTED NAME (Last, First, Middle Initial)	b. SIGNATURE
c. TITLE	

DD Form 2375, MAY 85

DD FORM 2377, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) RED/GREEN COLOR VISION TEST

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
RED / GREEN COLOR VISION TEST

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SOCIAL SECURITY NUMBER OF APPLICANT
FRELIX, ROSS L.	900-00-0009

3. "I certify that Applicant (Examinee) (X One) [XX] a. CAN [ ] b. CAN NOT distinguish and identify objects that are bright RED and bright GREEN," i.e., balls of yarn, colored balls, construction paper. *(Do not readminister standard color vision test.)*

4. EXAMINER

a. TITLE OF EXAMINER	b. SIGNATURE OF EXAMINER	c. DATE SIGNED
Color Vision Specialist	Norman D Charles	7 May 87

DD Form 2377, MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

RED / GREEN COLOR VISION TEST

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER OF APPLICANT

3. "I certify that Applicant (Examinee) *(X One)* ☐ a. CAN ☐ b. CAN NOT distinguish and identify objects that are bright RED and bright GREEN," i.e., balls of yarn, colored balls, construction paper. *(Do not readminister standard color vision test.)*

4. EXAMINER

a. TITLE OF EXAMINER	b. SIGNATURE OF EXAMINER	c. DATE SIGNED

DD Form 2377, MAY 85

DD FORM 2378, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEADACHES

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF HISTORY REGARDING HEADACHES

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USE: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

INSTRUCTIONS

Please provide the following information concerning your history of headaches. Be very specific in your answers. If additional space is needed, please use reverse side of this form.

1. HOW OFTEN DO YOUR HEADACHES OCCUR? *(e.g., monthly, quarterly, every six months, etc.)*

Once a month.

2. WHEN HEADACHES OCCUR, WHAT IS THEIR FREQUENCY? *(e.g., once a day, twice, three times, etc.)*

Once a day.

3. HOW LONG DO THE HEADACHES USUALLY LAST? *(e.g., 1 hour, 2 hours, 6 hours, etc.)*

2 hours

4. HAVE YOU EVER TAKEN ANY MEDICATIONS FOR YOUR HEADACHES? IF SO, PLEASE EXPLAIN IN DETAIL *(e.g., what medication, usual dose, etc.)*

Tylenol

5. DO HEADACHES INTERFERE WITH NORMAL ACTIVITIES?

No

6. LIST ANY OTHER PERTINENT INFORMATION CONCERNING THIS PROBLEM

N/A

7. HAS A PHYSICIAN DIAGNOSED YOUR HEADACHES? IF SO, WHAT WERE THE FINDINGS?

Tension headaches

8. APPLICANT

a. SIGNATURE	b. SOCIAL SECURITY NUMBER	c. DATE SIGNED
Kay Harold	001-00-1001	5 May 87

DD Form 2378, MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF HISTORY REGARDING HEADACHES

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USE: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

INSTRUCTIONS

Please provide the following information concerning your history of headaches. Be very specific in your answers. If additional space is needed, please use reverse side of this form.

1. HOW OFTEN DO YOUR HEADACHES OCCUR? *(e.g., monthly, quarterly, every six months, etc.)*

2. WHEN HEADACHES OCCUR, WHAT IS THEIR FREQUENCY? *(e.g., once a day, twice, three times, etc.)*

3. HOW LONG DO THE HEADACHES USUALLY LAST? *(e.g., 1 hour, 2 hours, 6 hours, etc.)*

4. HAVE YOU EVER TAKEN ANY MEDICATIONS FOR YOUR HEADACHES? IF SO, PLEASE EXPLAIN IN DETAIL *(e.g., what medication, usual dose, etc.)*

5. DO HEADACHES INTERFERE WITH NORMAL ACTIVITIES?

6. LIST ANY OTHER PERTINENT INFORMATION CONCERNING THIS PROBLEM

7. HAS A PHYSICIAN DIAGNOSED YOUR HEADACHES? IF SO, WHAT WERE THE FINDINGS?

8. APPLICANT

a. SIGNATURE	b. SOCIAL SECURITY NUMBER	c. DATE SIGNED

DD Form 2378, MAY 85

DD FORM 2379, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HEAD INJURY

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF HISTORY REGARDING HEAD INJURY

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT
BENNETT, TERRY G.	001-1[illegible] 11

INSTRUCTIONS

Please answer the following questions regarding head injury. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. HOW DID THE HEAD INJURY OCCUR?
Playing football

4. HOW OLD WERE YOU WHEN IT HAPPENED?
15 years old

5. WERE YOU UNCONSCIOUS? HOW LONG?
yes, 2 minutes

6. DID YOU HAVE A SKULL FRACTURE?
No

7. DID YOU HAVE ANY SYMPTOMS AFTER THE INJURY, FOR EXAMPLE; HEADACHES, VOMITING, AMNESIA, DOUBLE VISION, DIZZINESS, ETC.? HOW LONG DID THE SYMPTOM(S) LAST?
Dizziness for 5 minutes.

8. WERE ANY ADDITIONAL PROCEDURES ACCOMPLISHED SUCH AS ELECTROENCEPHALOGRAM, BRAIN SCAN, BURR HOLES, PNEUMOENCEPHALOGRAM, ETC.?
Skull x-rays which were normal.

9. SIGNATURE OF APPLICANT	10. DATE SIGNED
Terry G. Bennett	7 May 87

DD Form 2379, MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF HISTORY REGARDING HEAD INJURY

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

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DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT

INSTRUCTIONS

Please answer the following questions regarding head injury. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. HOW DID THE HEAD INJURY OCCUR?
4. HOW OLD WERE YOU WHEN IT HAPPENED?
5. WERE YOU UNCONSCIOUS? HOW LONG?
6. DID YOU HAVE A SKULL FRACTURE?
7. DID YOU HAVE ANY SYMPTOMS AFTER THE INJURY, FOR EXAMPLE; HEADACHES, VOMITING, AMNESIA, DOUBLE VISION, DIZZINESS, ETC.? HOW LONG DID THE SYMPTOM(S) LAST?
8. WERE ANY ADDITIONAL PROCEDURES ACCOMPLISHED SUCH AS ELECTROENCEPHALOGRAM, BRAIN SCAN, BURR HOLES, PNEUMOENCEPHALOGRAM, ETC.?

9. SIGNATURE OF APPLICANT	10. DATE SIGNED

DD Form 2379, MAY 85

DD FORM 2380, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING SLEEPWALKING

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
STATEMENT OF HISTORY REGARDING SLEEPWALKING

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT
TIPTOE, JOHNNY T.	100-01-1000

INSTRUCTIONS

Please answer the following questions regarding sleepwalking. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING?

Twice a month

4. WHEN DID YOU LAST SLEEPWALK (month and year) (age)?

April 1987, 17 years old

5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING.

I get up in the middle of the night and walk into the living room. I wake up in the living room and don't remember how I got there.

6. SIGNATURE OF APPLICANT	7. DATE SIGNED
Johnny T. Tiptoe	1 May 87

DD Form 2380, MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF HISTORY REGARDING SLEEPWALKING

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT *(Last, First, Middle Initial)*	2. SSN OF APPLICANT

INSTRUCTIONS

Please answer the following questions regarding sleepwalking. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. HOW FREQUENT ARE EPISODES OF SLEEPWALKING?

4. WHEN DID YOU LAST SLEEPWALK *(month and year) (age)*?

5. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR SLEEPWALKING.

6. SIGNATURE OF APPLICANT	7. DATE SIGNED

DD Form 2380, MAY 85

DD FORM 2381, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING MOTION SICKNESS

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF HISTORY REGARDING MOTION SICKNESS

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT
MELLS, FRED D.	100-00-.010

INSTRUCTIONS

Please answer the following questions regarding motion sickness. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. TYPE OF MOTION SICKNESS (SUCH AS, AIR, TRAIN, CAR, SEA, SWING, CARNIVAL RIDES, ETC.).
Sea sickness

4. WHAT AGE DID IT FIRST HAPPEN?
14 years old

5. HOW SEVERE AND FREQUENT ARE EPISODES?
I was sick all day while deep sea fishing. This happened only once.

6. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR MOTION SICKNESS.
I have gone fishing since and not gotten sea sick.

7. SIGNATURE OF APPLICANT	8. DATE SIGNED
Fred D Mells	2 Apr 87

DD Form 2381, MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF HISTORY REGARDING MOTION SICKNESS

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT

INSTRUCTIONS

Please answer the following questions regarding motion sickness. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. TYPE OF MOTION SICKNESS (SUCH AS, AIR, TRAIN, CAR, SEA, SWING, CARNIVAL RIDES, ETC.).

4. WHAT AGE DID IT FIRST HAPPEN?

5. HOW SEVERE AND FREQUENT ARE EPISODES?

6. PROVIDE ANY OTHER PERTINENT INFORMATION RELATED TO YOUR MOTION SICKNESS.

7. SIGNATURE OF APPLICANT	8. DATE SIGNED

DD Form 2381, MAY 85

DD FORM 2382, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF HISTORY REGARDING HAY FEVER, SINUSITIS, ASTHMA AND/OR ALLERGIES

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)
STATEMENT OF HISTORY REGARDING HAY FEVER, SINUSITIS, ASTHMA AND/OR ALLERGIES

Privacy Act Statement

AUTHORITY: Title 10, US Code 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT
MARPEL, MARY M.	000-01-0000

INSTRUCTIONS

Please answer the following questions regarding hay fever, sinusitis, asthma and/or allergies. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. NUMBER AND APPROXIMATE DATES OF ATTACKS OR EPISODES.
5 episodes: 23 May 85, 14 July 85, 1 October 85, 30 January 86 and 14 Apr 87.

4. SIGNS, SYMPTOMS AND DURATION OF ATTACKS.
Wheezing, shortness of breath.

5. TYPE AND AMOUNT OF MEDICATION USED AND LENGTH OF TREATMENT.
Theodur 300 mgs, 3 times a day for 30 days.

6. TYPE OF AND DURATION OF HYPOSENSITIZATION (DESENSITIZATION) (IF ANY) EMPLOYED, GIVING INCLUSIVE DATES.
N/A

7. HAS MAINTENANCE DOSE BEEN ATTAINED?
Proventil as needed prior to exercises.

8. AGE AT LAST ATTACK OF ASTHMA AND DATE LAST ASTHMA MEDICATION WAS USED.
16 years old

9. IS THERE ANY HISTORY OF ALLERGIC SKIN DISORDER? IF YES, PLEASE EXPLAIN.
No

10. SIGNATURE OF APPLICANT	11. DATE SIGNED
Mary M Marpel	14 May 87

DD Form 2382, MAY 87 *Previous edition may be used.*

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF HISTORY REGARDING HAY FEVER, SINUSITIS, ASTHMA AND/OR ALLERGIES

Privacy Act Statement

AUTHORITY: Title 10, US Code 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

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DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT

INSTRUCTIONS

Please answer the following questions regarding hay fever, sinusitis, asthma and/or allergies. Be very specific in your answers. If additional space is needed, use the reverse side of this form.

3. NUMBER AND APPROXIMATE DATES OF ATTACKS OR EPISODES.
4. SIGNS, SYMPTOMS AND DURATION OF ATTACKS.
5. TYPE AND AMOUNT OF MEDICATION USED AND LENGTH OF TREATMENT.
6. TYPE OF AND DURATION OF HYPOSENSITIZATION (DESENSITIZATION) (IF ANY) EMPLOYED, GIVING INCLUSIVE DATES.
7. HAS MAINTENANCE DOSE BEEN ATTAINED?
8. AGE AT LAST ATTACK OF ASTHMA AND DATE LAST ASTHMA MEDICATION WAS USED.
9. IS THERE ANY HISTORY OF ALLERGIC SKIN DISORDER? IF YES, PLEASE EXPLAIN.

10. SIGNATURE OF APPLICANT	11. DATE SIGNED

DD Form 2382, MAY 87 *Previous edition may be used*

DD FORM 2383, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) STATEMENT OF USE REGARDING MEDICATION

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF USE REGARDING MEDICATION

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

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DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT
WHITE, REBECCA L.	010-00-1010

INSTRUCTIONS

Please answer the following questions regarding use of medication. Be very specific in your answers. If additional space is needed, use reverse side.

3. TYPE OF MEDICATION
Actifed

4. REASON FOR USAGE
Allergies

5. HOW LONG HAVE YOU TAKEN THIS MEDICATION?
13 days

6. HAVE YOU TAKEN ANY OTHER MEDICATION IN THE LAST 90 DAYS PRIOR TO PHYSICAL? (List type and reason for usage)
No

7. SIGNATURE OF APPLICANT	8. DATE SIGNED
Rebecca L White	5 May 87

DD Form 2383, MAY 85

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

STATEMENT OF USE REGARDING MEDICATION

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and Executive Order 9397.

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a U.S. Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USE: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The Social Security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT

INSTRUCTIONS

Please answer the following questions regarding use of medication. Be very specific in your answers. If additional space is needed, use reverse side.

3. TYPE OF MEDICATION

4. REASON FOR USAGE

5. HOW LONG HAVE YOU TAKEN THIS MEDICATION?

6. HAVE YOU TAKEN ANY OTHER MEDICATION IN THE LAST 90 DAYS PRIOR TO PHYSICAL? (List type and reason for usage.)

7. SIGNATURE OF APPLICANT	8. DATE SIGNED

DD Form 2383, MAY 85

DD FORM 2489, DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) FARNSWORTH LANTERN COLOR VISION TEST

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

FARNSWORTH LANTERN COLOR VISION TEST

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. SSN OF APPLICANT
MOORE, JOHN X.	000-00-0100

INSTRUCTIONS TO EXAMINERS

Please read reverse side of this form before administering this test.

Indicate by letters in each given block which colors were observed by the examinee for each run of the test (e.g., R/W, G/R, etc.).

	1	2	3	4	5	6	7	8	9	NUMBER OF ERRORS PER RUN
1st RUN	G/R	W/W	G/W	G/R	R/G	W/R	W/W	G/W	R/R	3
2nd RUN	G/R	W/G	G/W	G/G	R/G	W/R	W/W	R/W	R/R	Ø
3rd RUN	G/R	W/R	G/W	G/G	R/G	W/R	W/W	R/W	R/R	Ø

3. REMARKS *(Continue on reverse if necessary)*

4. SIGNATURE OF EXAMINER	5. DATE SIGNED
D. Cheuvront USAF	16 Jun 87

DD Form 2489, FEB 87

FARNSWORTH LANTERN COLOR VISION TEST - INSTRUCTIONS

PREPARATION FOR TESTING

1. Give the test in a normally lighted room; screen from glare; exclude sunlight. Examinee should not face the source of room illumination.

2. Only one person should be tested at a time. (Others shall not be allowed to watch.)

3. Station examinee eight feet from lantern.

4. If examinee ordinarily wears contact lenses or glasses for distance, they should be worn. Color correcting lenses, if worn, must be removed prior to testing.

ADMINISTRATION AND SCORING

1. Instruct examinee, "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time - in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors - red, green, and white - and top first."

2. Turn knob at top of lantern to change lights; depress button in center of knob to expose lights. Maintain regular timing of about two seconds per light.

3. Expose the lights in random order starting with a RG or GR combination (Numbers 1 or 5), continuing until each of the nine combinations has been exposed.

4. If no errors are made on this first run of nine pairs of lights, examinee is passed.

5. If any errors are made on this first run, give two more complete runs.

6. Average the errors of these last two runs. If an average of more than one error per run is made, examinee is failed. If an average of one, or less than one error per run is made, examinee is passed.

7. An error is considered the miscalling of one or both of a pair of lights; if an examinee changes his/her response before the next light is presented, record the second response only.

8. If an examinee says "yellow," "pink," etc., you should say, "There are only three colors - red, green, and white."

9. If an examinee takes a long time to respond, you should say, "As soon as you see the lights, call them."

REMARKS *(Continued)*

DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)

FARNSWORTH LANTERN COLOR VISION TEST

Privacy Act Statement

AUTHORITY: Title 10, USC 133, 3012, 5031, 8012 and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE: To update a medical file as part of the application process to a US Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Programs, or the Uniformed Services University of Health Sciences (USUHS).

ROUTINE USES: To determine medical acceptability for one or more of the service academies, ROTC or USUHS. Information will be released to authorized personnel involved in the selection process. The social security number (SSN) is used for positive identification.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy.

1. NAME OF APPLICANT *(Last, First, Middle Initial)*	2. SSN OF APPLICANT

INSTRUCTIONS TO EXAMINERS

Please read reverse side of this form before administering this test.

Indicate by letters in each given block which colors were observed by the examinee for each run of the test (e.g., R/W, G/R, etc.).

	1	2	3	4	5	6	7	8	9	NUMBER OF ERRORS PER RUN
1st RUN										
2nd RUN										
3rd RUN										

3. REMARKS *(Continue on reverse if necessary)*

4. SIGNATURE OF EXAMINER	5. DATE SIGNED

DD Form 2489, FEB 87

FARNSWORTH LANTERN COLOR VISION TEST - INSTRUCTIONS

PREPARATION FOR TESTING

1. Give the test in a normally lighted room; screen from glare; exclude sunlight. Examinee should not face the source of room illumination.

2. Only one person should be tested at a time. (Others shall not be allowed to watch.)

3. Station examinee eight feet from lantern.

4. If examinee ordinarily wears contact lenses or glasses for distance, they should be worn. Color correcting lenses, if worn, must be removed prior to testing.

ADMINISTRATION AND SCORING

1. Instruct examinee, "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time - in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors - red, green, and white - and top first."

2. Turn knob at top of lantern to change lights; depress button in center of knob to expose lights. Maintain regular timing of about two seconds per light.

3. Expose the lights in random order starting with a RG or GR combination (Numbers 1 or 5), continuing until each of the nine combinations has been exposed.

4. If no errors are made on this first run of nine pairs of lights, examinee is passed.

5. If any errors are made on this first run, give two more complete runs.

6. Average the errors of these last two runs. If an average of more than one error per run is made, examinee is failed. If an average of one, or less than one error per run is made, examinee is passed.

7. An error is considered the miscalling of one or both of a pair of lights; if an examinee changes his/her response before the next light is presented, record the second response only.

8. If an examinee says "yellow," "pink," etc., you should say, "There are only three colors - red, green, and white."

9. If an examinee takes a long time to respond, you should say, "As soon as you see the lights, call them."

REMARKS *(Continued)*

DD Form 2489, FEB 87

ADDITIONAL INSTRUCTIONS FOR PERFORMING MEDICAL TESTS

This attachment gives guidelines on the additional medical information needed along with the physical examination of applicants to a US service academy (Air Force, Military, Naval, Coast Guard, Merchant Marine), Four-Year ROTC Scholarship, or the USUHS.

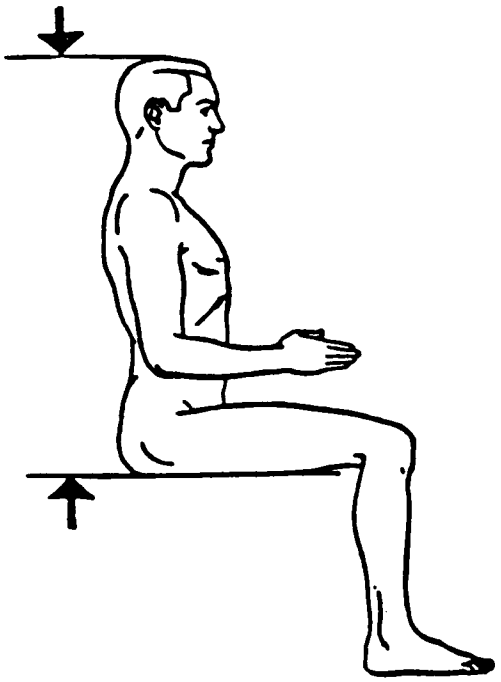
a. Reading Aloud Test (RAT). Administer the RAT to all applicants. The test must be given as follows:

(1) Have the examinee stand erect, face the examiner across the room, and read aloud the statement in 2 below, as if he or she were confronting a class of students.

(2) If he or she pauses, even momentarily on any phrase or word, the examiner immediately and sharply says, "What's that?" and makes the examinee start over again with the first sentence of the text. The true stammerer usually will halt again at the same word or phonetic combination, and will often show serious stammering.

"You wish to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat, usually minus several buttons; yet, he still thinks as swiftly as ever. A long flowing beard clings to his chin giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in winter, when the ooze of snow or ice is present, he slowly takes a short walk each day. We have often urged him to walk more and smoke less, but he always answers, "Banana oil!" Grandfather likes to be modern in his language."

b. Sitting Height. To measure sitting height, have the examinee sit on a hard surface, hips flexed at 90 degrees (°), lower legs dangling free, and torso erect, with head facing directly forward. Measure from the top of the head to the top of the hard surface the examinee is seated upon. Measure sitting height to the nearest quarter of an inch. (See diagram.)



c. Near Point of Accommodation. Have the examinee wear his or her usual corrective lenses. The object of the test is to determine the nearest point where the examinee can read print that is 1 millimeter (mm) (.62 Snellen-Metric), or J-2) high. Hold the test card so near the eye that the examinee cannot read it, then slowly move it away until the examinee can read the print correctly. Record the results for each eye in diopters. If an ophthalmologist or optometrist is doing the test, with the manifest refraction findings in place, use monocular push-up amplitude of accommodation and record the results for each eye in diopters.

d. Near Point of Convergence (NPC). The object of the test is determining the point on a ruler where eye convergence is the greatest. Place the ruler's zero mark about 15 mm from the corneal surface. Start the movable object at the far end of the ruler, and move it slowly toward the nose. The point of convergence is the point on the ruler where eye convergence is the greatest, but without breaking fusion. Record the results in millimeters.

e. Red Lens Test. The examinee should be 30 inches from a tangent screen or a central fixation point. The fixation point should be on a plain wall, 48 inches from the floor, with intersecting lines of 45°, 90°, 135°, and 180°,

running at least 20 inches from the point of fixation. These lines may be marked at 4-inch intervals, and a cord 30 inches long fastened at the fixation point to measure the testing distance. the examinee's eye should be on an exact line, perpendicular to the fixation point so that the head and eyes are not tilted in any direction. Seat the examinee on an adjustable stool and steady his or her head by placing the chin on a chin rest, so that the visual axis will not change during the test. Put a red lens in front of one of the examinee's eyes. Then move a point of light outward in the six cardinal directions from the center of the screen; right, left, up and to the right, up and to the left, down and to the right, and down and to the left. Instruct the examinee to follow the light with his or her eyes, without moving his or her head, and to tell you if there is either a change in the color of the light (suppression) or a doubling of the light (diplopia). Demonstrate a change in the color of the light at the beginning of the test, showning that it may be either red, white, or pink, by using an occluder. Move the light into one of the upper diagonal fields until the brow cuts off the view from one, to verify that the examinee understands. The examinee should report a change in color. Place a five diopter prism, base up or base down, before one eye to produce diplopia, which the examinee should report. This will avoid the danger of routine negative responses. If you wish, alternate this prism with a plano lens of the same size to confuse the examinee. Note and record the point on the screen if the examinee has diplopia or suppression when no prism is being used.

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